

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

45179

FILED JAN 20 1954

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State File No. 12173

Registrar's No. 12173

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No. _____		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS</u>		c. LENGTH OF STAY (In this place) <u>10 days</u>		c. CITY OR TOWN <u>Webster Groves</u>		d. Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>				e. STREET ADDRESS (If rural, give location) <u>4 Sappington Spur</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>GRACE</u>		b. (Middle) <u>S.</u>		c. (Last) <u>ALCORN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>December 25, 1953</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>11-25-1873</u>		9. AGE (In years last birthday) <u>80</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Mins. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Greenfield Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>John Smead</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Wilson</u>			14. NAME OF HUSBAND OR WIFE <u>Herbert R Alcorn</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>H.S. Alcorn 4 Sappington Spur</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.								
MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH		
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral vascular hemorrhage; multiple</u>						<u>14 days</u>		
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Auricular fibrillation</u> <u>Arteriosclerotic heart disease and</u> DUE TO (c) <u>Hypertensive cardiovascular disease</u>						<u>2 years</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						<u>20 years</u>		
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____		21f. HOW DID INJURY OCCUR? <u>4200</u>		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						
22. I hereby certify that I attended the deceased from <u>12/14/53</u> , 19____, to <u>12/25/53</u> , 19____, that I last saw the deceased alive on <u>12/25/53</u> , 19____, and that death occurred at <u>1:25 p.m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>FR Bradley M.D.</u>				23b. ADDRESS <u>BARNES HOSPITAL</u>		23c. DATE SIGNED <u>12/25/53</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>12-28-1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Glendale Ohio.</u>			
DATE REC'D BY LOCAL REG. <u>DEC 26 1953</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith mo</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Parker - Aldrich H. Dwyer Mo</u>				

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....  
*Leslie Adch*

Licensed Embalmer No. *4395*  
P. O. Address *Whiter Grove*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.