

THE DIVISION OF HEALTH - MISSOURI  
STANDARD CERTIFICATE OF DEATH

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>	c. LENGTH OF STAY (In this place) <b>9 days</b>	c. CITY OR TOWN <b>St. Louis</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. John's Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>3937 Childress</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Reba</b> b. (Middle) <b>Jane</b> c. (Last) <b>Grace</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>May 12, 1954</b>
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5. SEX <b>Fe</b>	6. COLOR OR RACE <b>Wh</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Oct. 8-1894</b>	9. AGE (In years last birthday) <b>59</b>	IF UNDER 1 YEAR Months   Days   Hours   Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance Co.</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Graves County, Kentucky</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>George W. Greene</b>	13b. MOTHER'S MAIDEN NAME <b>Edna Johnson</b>	14. NAME OF HUSBAND OR WIFE <b>Lennon Grace</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>497-03-5763</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Paul Hale, 3937 Childress</b>	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral vascular accident</b>		Ante-term
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Essential hypertension</b> DUE TO (c) <b>Generalized arteriosclerosis</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			Ante-term

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>331X</b>

22. I hereby certify that I attended the deceased from **1950**, to **May 12, 1954**, that I last saw the deceased alive on **May 12, 1954**, and that death occurred at **2:30 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE <i>[Signature]</i>	(Degree or title)	23b. ADDRESS <b>634 N. Grand</b>	23c. DATE SIGNED <b>5/13/54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>May 14, 1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Mayfield, Kentucky</b>	24d. LOCATION (City, town, or county) (State) <b>Mayfield, Kentucky</b>
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DATE REC'D BY LOCAL REG. <b>MAY 13 1954</b>	REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>C. Hoffmeister Colonial Mortuary, Chippewa</b>	ADDRESS <b>6464</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. W. C. Missey Jr..

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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 emb  
by me, or by ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Harold J. Schenck*.....

Licensed Embalmer No. *2679*

P. O. Address *7814 J. P. Road*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F  
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.