

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29402

FILED AUG 23 1954

Registrar's No. 1980

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 547

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Richmond Heights		c. LENGTH OF STAY (In this place) 30 yrs.	
d. FULL NAME OF HOSPITAL OR INSTITUTION. 7109 Nashville Ave.		e. STREET ADDRESS (If rural, give location) 7109 Nashville Ave.	

3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) Josephine c. (Last) Grady			4. DATE OF DEATH (Month) (Day) (Year) August 13, 1954
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH March 17, 1873	9. AGE (In years last birthday) 81	10. UNDER 1 YEAR 4	11. UNDER 2 WKS. Hours 27 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At home	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Charles J. Healy	13b. MOTHER'S MAIDEN NAME Alice Slattery	14. NAME OF HUSBAND OR WIFE John E. Grady
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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) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mary A. McGoff ADDRESS 7109 Nashville
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) arterio-sclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 years
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Sensitivity		
	DUE TO (c) Fracture Right Hip		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		3 months	

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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Aug 13, 1954**, to **Aug 13, 1954**, that I last saw the deceased alive on **Aug 13, 1954**, and that death occurred at **11:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Thos. A. Dell MD	23b. ADDRESS 7346 Maplewood 17 MO.	23c. DATE SIGNED Aug 14, 1954
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24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE Aug. 16, 54	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis Mo.
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DATE REC'D BY LOCAL REG. 8/14/54	REGISTRAR'S SIGNATURE Herbert R. ...	25. FUNERAL DIRECTOR'S SIGNATURE H. Buchalage ADDRESS 6536 Clayton Rd.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

✓ 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..... *Paul A. Wachter*

Licensed Embalmer No. *478*

P. O. Address *St. Louis*

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.