

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9639
2860

State File No.

Registrar's No.

FEB 11 1955

BIRTH NO. 17728-55 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 <u>Missouri</u> b. COUNTY	
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>17hrs 30mins</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Romer G. Phillips</u>		d. STREET ADDRESS (If rural, give location) <u>1320 N. Sarah St.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>(Twin #1)</u> b. (Middle) c. (Last) <u>Gregory</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>3 6 55</u>	
5. SEX <u>Fem.</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <u>3-5-55</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>
10c. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. CITIZEN OF WHAT COUNTRY?	

13a. FATHER'S NAME <u>George Gregory</u>	13b. MOTHER'S MAIDEN NAME <u>Ruthie Mae Griffin</u>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <u>William H. Smiley</u>	ADDRESS <u>2601 N. Whittier</u>
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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, asthenia, 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>Premature birth, neonatal death</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>7735</u>

22. I hereby certify that I attended the deceased from 3-5- 15, to 3-6- 1955, that I last saw the deceased alive on 3-6- 1955, and that death occurred at 9:00a m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>William H. Smiley M. D.</u>	23b. ADDRESS <u>2601 N. Whittier</u>	23c. DATE SIGNED <u>3-8-55</u>
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <u>3-31-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>
		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>

DATE REC'D BY LOCAL REG. <u>MAR 30 1955</u>	REGISTRAR'S SIGNATURE <u>J. Carl Smith mo</u>	25. FUNERAL DIRECTOR'S SIGNATURE, ADDRESS <u>Newland Mortuary Service</u>
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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
Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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 this body is not embalmed, fact should be so stated above.