

FILED MAY 25 1955

STANDARD CERTIFICATE OF DEATH

16658

State File No.

BIRTH NO.

REG. DIST. NO.

318

PRIMARY REG. DIST. NO.

1003

Registrar's No.

4135

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, write RURAL and give town OR TOWN St. Louis

c. LENGTH OF STAY (in this place)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

a. STATE Missouri

b. COUNTY

c. CITY OR TOWN St. Louis

d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital

STREET ADDRESS

(If rural, give location)

19 4333 Washington Ave. 219/10

3. NAME OF DECEASED

(Type or Print)

a. (First)

Elizabeth

b. (Middle)

Margaret

c. (Last)

Grant

4. DATE OF DEATH (Month) (Day) (Year)

5 7 55

5. SEX

F

6. COLOR OR RACE

Col.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Feb. 1, 1879

9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Mins.

76

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

Chiropodist

11. BIRTHPLACE (City and State or Foreign Country)

Natchez, Mississippi

12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME

Frank Holliday

13b. MOTHER'S MAIDEN NAME

Eliza Collins

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S SIGNATURE OR NAME ADDRESS

David M. Grant, 3309 Arsenal

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)

Cerebral Thrombosis. (Left)

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.

Generalized Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

Undt.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO

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 NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-25-1955, to 5-7-1955, that I last saw the deceased alive on 5-7-1955, and that death occurred at 6:50a m., from the causes and on the date stated above. 332X

23a. SIGNATURE

Edw. B. Williams

(Degree or title)

M.D.

23b. ADDRESS

2601 N. Whittier St.

23c. DATE SIGNED

5-9-55

24a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24b. DATE

May 11, 1955

24c. NAME OF CEMETERY OR CREMATORY

St. Peter's Cemetery

24d. LOCATION (City, town, or county) (State)

St. Louis, Mo

DATE REC'D BY LOCAL REG. MAY 10 1955

REGISTRAR'S SIGNATURE

Charles Smith mo

25. FUNERAL DIRECTOR'S SIGNATURE

J. W. Hughes

ADDRESS

2620 Lawton

(Licensed Embalmer's Statement on Reverse Side)

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

James A. Carter

Licensed Embalmer No. *1046*

P. O. Address *1046*

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.