

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-041625

STATE FILE NUMBER

11443

FILED DEC 9 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

300  
-57

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURY b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 01 2629 DICKSON		Length of stay in lb	d. STREET ADDRESS (If outside, give location) 2219 2629 DICKSON		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARANDA GRANT			4. DATE OF DEATH Month Day Year 11 26 58			
5. SEX F 3	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAR. 16 186A	9. AGE (In years last birthday) 89 IF UNDER 1 YEAR Months Days 8 10 IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Foley MO, c		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Geo. Grant		13b. MOTHER'S MAIDEN NAME Harriet Harrison		14. NAME OF HUSBAND OR WIFE Geo. Grant		
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. L	17. INFORMANT Eula Bankhead Dickson Address 2629			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myo-carditis Chronic Nephritis DUE TO (b) Asthma, Rheumatism, Arteriosclerosis DUE TO (c) 422.2 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)				
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.						
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from Aug. 58 to Nov. 26 and last saw her alive on Nov. 25-58 Death occurred at 12:30 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE E. Smith, M.D.			22b. ADDRESS 3000 E. Eastway		22c. DATE NOV 28 1958	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 12-2 1958	23c. NAME OF CEMETERY OR CREMATORY GREENWOOD		23d. LOCATION (City, town, or county) (State) 6500 St. Clair Av. MO		
24. FUNERAL DIRECTOR A. F. WALTER		ADDRESS 2707 Stoddard	25. DATE RECD. BY LOCAL REG. NOV 28 '58	26. REGISTRAR'S SIGNATURE Carl Smith M.D. dem		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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 *W. Claude Gordon*

Licensed Embalmer No. *3489*  
P. O. Address *4575 Alca*

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.