

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-045711

STATE FILE NUMBER

12781

FILED JAN 12 1958

Registration District No. 318

Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		Length of stay in 1b 2/1/58	d. STREET ADDRESS (If outside, give location) 4444 Cottage
3. NAME OF DECEASED (Type or print) First Middle Last Lillie Pearl Grant		4. DATE OF DEATH Month Day Year 12 30 58	
5. SEX Female 3	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 25, 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 65 FUNDING YEAR Months Days Hours Min.
11. BIRTHPLACE (City and state or country) St. Louis, Mo		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME UNKNOWN		13b. MOTHER'S MAIDEN NAME MARY ?	14. NAME OF HUSBAND OR WIFE IRVING 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. NONE	17. INFORMANT IRVING GRANT 4444 Cottage Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE. Conditions, if any, which gave rise to above cause (b) Due to (b) 420.0 stating the underlying cause (c) Due to (c) 5/59 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 undet.
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.		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 12-29-58 to 12-30-58 and last saw her alive on 12-30-58 Death occurred at 2:15 P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Paul H. Larson, M.D.		22b. ADDRESS 2601 Whittier Street	22c. DATE SIGNED 12-31-58
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 1-5-59	23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Ave. St. Louis City Mo.
24. FUNERAL DIRECTOR English F. Home, 1123 N. Taylor		25. DATE RECD. BY LOCAL REG. JAN 3 59	26. REGISTRAR'S SIGNATURE J. Earl Smith M.D. (H.T.)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *H. C. Claude Gordon*.....

Licensed Embalmer No. *3489*.....

P. O. Address. *4575 Alder*.....

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.