

**FRI DIVISION OF HEALTH—STANDARD CERTIFICATE OF DEATH**

**-60-008272**

**FILED VS MAR 7 1960**

**2 2175**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

<b>1. PLACE OF DEATH</b> a. COUNTY		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b	c. CITY OR TOWN <b>St. Louis</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4419 St. Ferdinand</b>
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

<b>3. NAME OF DECEASED</b> (Type or print)	First	Middle	Last	<b>4. DATE OF DEATH</b>	Month	Day	Year
			<b>Grant</b>		<b>2</b>	<b>15</b>	<b>60</b>

<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>Negro</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input checked="" type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>2-15-60</b>	<b>9. AGE (last birthday)</b>	<b>IF UNDER 1 YEAR</b>	<b>IF UNDER 24 HR</b>
					Months	Days
						Hours
						Min.
						<b>38</b>

<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)	<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	<b>11. BIRTHPLACE</b> (City and state or country) <b>Saint Louis, Missouri</b>	<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>
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<b>13a. FATHER'S NAME</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>Mable Grant</b>	<b>14. NAME OF HUSBAND OR WIFE</b>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)	<b>16. SOCIAL SECURITY NO.</b>	<b>17. INFORMANT</b> <i>Hospital Records</i>	<b>Address</b> <b>2601 N. Whittier</b>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Premature birth, Neonatal death</b>	<b>INTERVAL BETWEEN ONSET AND DEATH</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____	

<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH</b> but not related to the terminal disease condition given in PART I (a) <b>Atelectasis</b>	<b>PART III. If deceased was female was there a pregnancy in last 90 days.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)
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<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. _____	Month, Day, Year
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<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	<b>COUNTY</b>	<b>STATE</b>
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**21. I attended the deceased from** 2-15-60 **to** 2-15-60 **and last saw him alive on** 2-15-60  
**Death occurred at** 3:15 **a.** \_\_\_\_\_ **m on the date stated above, and to the best of my knowledge, from the causes stated.**

<b>22a. SIGNATURE</b> <i>Paul Smith, M.D.</i>	<b>22b. ADDRESS</b> <b>2601 N. Whittier</b>	<b>22c. DATE SIGNED</b> <b>2-17-60</b>
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<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>FEB 29 1960</b>	<b>23b. DATE</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Anatomical Board</b>	<b>23d. LOCATION (City, town, or county)</b> <b>St. Louis, Mo.</b>
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<b>24. FUNERAL DIRECTOR</b> <b>Rowland Mortuary Svc.</b>	<b>ADDRESS</b> <b>404-06 Manchester</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <b>FEB 25 1960</b>	<b>26. REGISTRAR'S SIGNATURE</b> <i>Paul Smith, M.D.</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of 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 conform 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.