SSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

MAR 28 1961

-61-011212

STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2452

DATE AMENDED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Homer G. Phillips
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 5980 Romaine
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Earl; Middle; Last: Mc Grew

4. DATE OF DEATH: Month 3; Day 10; Year 61

5. SEX: Male

6. COLOR OR RACE: Negro

7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 1-6-1903

9. AGE (last birthday): 58

IF UNDER 1 YEAR: Months 2; Days 4

IF UNDER 24 HR: Hours; Min.

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

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country): MISSISSIPPI

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: JOSIAH McGRAW

13b. MOTHER'S MAIDEN NAME: LIZZIE MOODY

14. NAME OF HUSBAND OR WIFE: NONE

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

16. SOCIAL SECURITY NO.

17. INFORMANT: ROSIE MINOR Address: 5980 ROMAIN

INSTEAD OF

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac Infarction — INTERVAL BETWEEN ONSET AND DEATH: Undet.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c): 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 3-9-61 to 3-10-61 and last saw him alive on 3-10-61

Death occurred at 6:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Sydney R. Frasier (Degree or title) M.D.

22b. ADDRESS: 2601 N. Whittier St.

22c. DATE SIGNED: 3-13-61

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL

23b. DATE: 3-14-61

23c. NAME OF CEMETERY OR CREMATORY: OAKDALE

23d. LOCATION (City, town, or county) (State): LEMAY MO

24. FUNERAL DIRECTOR: RELIABLE FUNERAL HOME ADDRESS: 1389 UNION

25. DATE RECD. BY LOCAL REG.: MAR 14 1961

26. REGISTRAR'S SIGNATURE: Hoard Smith, M.D.

SHOULD READ

DOCUMENT

ITEM NO.

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 me, or by _____, Student Embalmer No._____ working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Clarence Good

Licensed Embalmer No. 4755

P. O. Address 1589 Unio

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.