

MISSOURI DIVISION OF PUBLIC HEALTH - STANDARD CERTIFICATE OF DEATH

10650-61-042210  
STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. \_\_\_\_\_

FILED NOV 28 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (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>4354 North Market</b>
			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Frances</b> Middle <b>Blanks</b> Last <b>Blanks</b>			4. DATE OF DEATH Month <b>11</b> Day <b>13</b> Year <b>61</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8 Aug 73</b>	9. AGE (last birthday) <b>88</b>	IF UNDER 1 Year Months <b>3</b> Days <b>5</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>N.I.I.</b>	11. BIRTHPLACE (City and state or country) <b>Paducah Kentucky</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13a. FATHER'S NAME <b>George Grundy</b>		13b. MOTHER'S MAIDEN NAME <b>Dorcas ?</b>		14. NAME OF HUSBAND OR WIFE <b>Dead</b>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>No</b>	17. INFORMANT <b>Mr Montel Blanke</b> Address <b>4354 N. Market</b>
---	-----------------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Undet.</b>
DUE TO (b) <b>Cerebral Thrombosis and Ischemia</b>		<b>Undet.</b>
DUE TO (c) <b>331X</b>		

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. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
---	--	---	--

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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 _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 <b>11-5-61</b> to <b>11-13-61</b> and last saw her <b>alive</b> on <b>11-13-61</b> Death occurred at <b>4:25</b> <b>P.</b> on the date stated above, and to the best of my knowledge, from the causes stated.
---

22a. SIGNATURE <b>Charles J. Forde, M.D.</b> (Degree or title)	22b. ADDRESS <b>2601 N. Whittier Street</b>	22c. DATE SIGNED <b>11-14-61</b>
--	---	----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>11/18/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenwood</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County Missouri</b>
--	---------------------------	---	--

24. FUNERAL DIRECTOR <b>Herman J. Smith</b> ADDRESS <b>42,7 w Labadie</b>	25. DATE RECD. BY LOCAL REG. <b>NOV 18 1961</b>	26. REGISTRAR'S SIGNATURE <b>Lead Smith M.D.</b>
---	---	--

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

THEY WHO SHOULD READ

**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 Arthur L. Halliard

Licensed Embalmer No. 4921

P. O. Address 3100 Boston Ave

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.