

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-032485

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8540**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

**FILED SEP 10 1962**

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Rev. 4/59

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|--|--|---|--|---|--|--|--|---|-----------------------------------|--|--|--------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |  | b. CITY (if outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>ST. LOUIS, MO.</b>                |  | Length of stay in 1b  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo</b> b. COUNTY <b>St. Louis</b> |  | c. CITY OR TOWN <b>Clayton</b>  |                                   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  |  |                    |  |
| c. FULL NAME OF (if NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Missouri Baptist Hosp.</b>   |  |   |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   |  | d. STREET ADDRESS (if outside, give location)<br><b>15 Lee Ave</b>   |  |   |                                   | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |  |                    |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Isabelle Scherrer Grant.</b>  |  |   |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>Sept. 2 1962</b>  |  |   |                                   |  |  |                    |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>7/5/1873</b>  |  | 9. AGE (last birthday)<br><b>89</b>   |                                   | IF UNDER 1 YEAR<br>Months Days Hours Min.                                  |  |                    |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>at home</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>at home</b>   |  | 11. BIRTHPLACE (City and state or country)<br><b>St. Louis, Mo.</b>  |  | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>   |                                   |  |  |                    |  |
| 13a. FATHER'S NAME<br><b>John Jacob Scherrer.</b>  |  |   |  | 13b. MOTHER'S MAIDEN NAME<br><b>Isabelle Follett.</b>   |  |  |  | 14. NAME OF HUSBAND OR WIFE<br><b>Charles Tellman Grant.</b>  |                                   |  |  |                    |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO</b>  |  |   |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address<br><b>Mrs. Julia Grant Sharp; 15 Lee Ave;</b>  |  |   |                                   |  |  |                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Emboli</b>  |  |   |  |   |  |  |  |   |                                   | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 d.</b>                           |  |                    |  |
| CONDITIONS (b) which give rise to starting cause (a) living cause (c) last.<br>DUE TO (b) <b>Arteriosclerotic Heart. Smor.</b>   |  |   |  |   |  |  |  |   |                                   |  |  |                    |  |
| DUE TO (c) <b>myocardial infarction + decompensation</b>   |  |   |  |   |  |  |  |   |                                   |  |  |                    |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I.<br><b>neoplasm of upper lobe fracture of rt. femur (6-7-62)</b>   |  |   |  |   |  |  |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |                                   |  |  |                    |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input 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.)<br><b>4200F</b>  |  |  |  |   |                                   |  |  |                    |  |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m. p.m.  |  |   |  | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>Home</b>                                |  | 20f. CITY, TOWN, OR LOCATION<br><b>Clayton</b>  |                                   | COUNTY<br><b>St. Louis</b>   |  | STATE<br><b>Mo</b> |  |
| 21. I attended the deceased from <b>Apr 6, 1962</b> to <b>Sept 2, 1962</b> last saw her alive on <b>Sept 2, 1962</b><br>Death occurred at <b>6 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |  |   |  |  |  |   |                                   |  |  |                    |  |
| 22a. SIGNATURE (Degree or title)<br><b>Richard Jones MD</b>  |  |   |  |   |  | 22b. ADDRESS<br><b>3720 Washington</b>   |  |   | 22c. DATE SIGNED<br><b>9-4-62</b> |  |  |                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE<br><b>9/5/1962</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Valhalla Cemetery</b>  |  | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis County, Missouri</b>   |  |   |                                   |  |  |                    |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Lupton Chapel Inc; 7233 Delmar Blvd</b>   |  |   |  | 25. DATE RECD. BY LOCAL REG.<br><b>SEP 4 1962</b>   |  | 26. REGISTRAR'S SIGNATURE<br><b>Paul Smith. M.D.</b>   |  |   |                                   |  |  |                    |  |

USE BLACK INK OR TYPEWRITER RIBBON

MEDICAL CERTIFICATION

Dr. R. H. Jones.  
3720 Washington Blvd

10017-1

Feb 10 57

4-4 PM

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 Arnold W. Schoene

Licensed Embalmer No. 3864

P. O. Address St. Louis, Mo.

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.