

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

22052

**1. PLACE OF DEATH**

County.....  
Township.....  
City..... **St. Louis**

Registration District No. **791**  
Primary Registration District No. **1003**  
(No. **6454 Southwest Ave**)

File No.....  
Registered No. **6221**  
St. .... Ward

**2. FULL NAME**

**Henry M. Greive**

(a) Residence. No. **6454 Southwest Ave. St.** **3** Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or wife of) **Athel Greive**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Sept. 23, 1872**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
**55 8 15**

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work **Watchman**  
(b) General nature of industry, business, or establishment in which employed (or employer) **RR. Exchange Bldg**  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **Washington**  
(STATE OR COUNTRY) **Mo.**

10. NAME OF FATHER **Martin Greive**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Germany**  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER **Sophia Dierking**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Germany**  
(STATE OR COUNTRY)

14. INFORMANT **Mrs. Athel Greive**  
(Address) **6454 Southwest Ave**

15. FILED **JUN 11 1928** **Max A. Stanley** REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **June 8 1928**

17. I HEREBY CERTIFY, That I attended deceased from **Sept. 1927** to **June 8 1928** that I last saw **h. a. w. alive on** **July 7, 1928**, and that death occurred, on the date stated above, at **12 noon**

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

**Cerebral hemorrhage  
Apoplexy**

CONTRIBUTORY (SECONDARY) **nephritis chronic**  
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED **at home**  
IF NOT AT PLACE OF DEATH...  
DID AN OPERATION PRECEDE DEATH... **no** DATE OF...  
WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS? **Physical exam**  
(Signed) **W. A. ...** M. D.  
, 19 (Address) **4303 Odor**

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Bellefontaine Cemetery** DATE OF BURIAL **June 11 1928**

20. UNDERTAKER **A. W. M. Laughlin** ADDRESS **1631 Moan**

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

