

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

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis** (No. **St. Anthony Hospital**)

21934

File No.....
Registered No. **5781**
St..... Ward.....

2. FULL NAME

Baby Grimm

(a) Residence, No. **Jaffron/Shapiro** St. **16** Ward.....
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **June 30 1933**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. min.
10 hours

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. James Mo**

13. NAME **Joseph Grimm**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Mattias Mo**

15. MAIDEN NAME **Alga Werkmeister**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Oberlin Mo**

17. INFORMANT (ADDRESS) **Joseph Grimm Mattias**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Mattias Mo** DATE **July 7 1933**

19. UNDERTAKER (ADDRESS) **Penick & Co 7819 Michigan**

20. FILED **JUL - 2 1933** **J. A. Bredack** Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **6-30-1933**

22. I HEREBY CERTIFY, That I attended deceased from **6-30-1933** to **6-30-1933**
I last saw him alive on **6-30-1933** Death is said to have occurred on the date stated above, at **1603 82nd** m.

The principal cause of death and related causes of importance were as follows:

Cerebral hemorrhage
Direct injury
Date of onset **6-30-33**

Other contributory causes of importance: **1603 82nd**

8
Name of operation..... Date of.....
What test confirmed diagnosis? **Hygial exam** Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury.....
Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?
If so, specify.....

(Signed) **J. A. Bredack** M. D.
(Address) **325 S. Grand St**

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.

