

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

Do not use this space.

1. PLACE OF DEATH **SED 10 1937**

791
1003

28690

County..... Registration District No.....
Township..... Primary Registration District No.....
City **St. Louis** (No. **Little Sisters of the Cross**)..... Ward)

2. FULL NAME **Henry Greszelman**
(a) Residence, No. **2209 Robert** St., **20** 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

MEDICAL CERTIFICATE OF DEATH

3. SEX **male**
4. COLOR OR RACE **white**
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Widower**
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Unknown**
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **October 5th 1852**
7. AGE **84** YEARS MONTHS **19** DAYS **27** If LESS than 1 day, hrs. or min.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **August 2th 1937**
22. I HEREBY CERTIFY, That I attended deceased from **July 28th 1937**, to **August 2nd 1937**
I last saw **living** on **August 1st 1937**. Death is said to have occurred on the date stated above, at **3 A.** m.
The principal cause of death and related causes of importance were as follows:

OCCUPATION
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. **Farmer**
10. Date deceased last worked at this occupation (month and year)..... 11. Total time (years) spent in this occupation.....

Cerebral Hemorrhage (apoplexy) (Date of onset)
Other contributory causes of importance:
Arteriosclerosis

MOTHER FATHER
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Madison Ill**
13. NAME **Henry Greszelman**
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**
15. MAIDEN NAME **Kate Hoagman**
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**

Name of operation..... **None** Date of.....
What test confirmed diagnosis? **Clinical** Was there an autopsy? **No.**

17. INFORMANT **Sister Jeanne** (ADDRESS) **2209 Robert St**
18. BURIAL, CREMATION, OR REMOVAL PLACE **Calvary Cem** DATE **8-3-37**

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury....., 19.....
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.....

19. UNDERTAKER **ARTHUR S. DONNELLY** (ADDRESS) **3540 LINDELL BLVD**
20. FILED **AUG 2-10 1937** **J. Bredeck** Registrar.

24. Was disease or injury in any way related to occupation of deceased? **No.**
If so, specify..... (Signed) **Anthony A. Prekacki** M. D. (Address) **1525 a Cass Ave.**

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.

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