

REC'D JUN 12 1939

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

17153
Do not use this space.

791
1008

1. PLACE OF DEATH

(a) County Registration District No.
(b) Township Primary Registration District No. Registered No. **4687**
(c) City St. Louis Mo (d) Street No. BARNES HOSPITAL St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME GRONE, HAZEL MAY

(a) Residence, No. 4274a RUSSELL St. 17
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 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) Oct. 2, 1917
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
21 7 20
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Beauty operator
9. Industry or business in which work was done, as 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. Louis, Missouri

FATHER 13. NAME Charles G. Grone

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

MOTHER 15. MAIDEN NAME Florence Kyle

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT (ADDRESS) Charles Grone 4274a Russell

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Paul Churchyard 5/25/39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Edith E. Ambruster 4234 Manchester

20. MAY 24 1939 J. F. Budick Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5/22/39, 19

22. I HEREBY CERTIFY, That I attended deceased from 3-22, 1939, to 5-22, 1939
I last saw him alive on 5-22, 1939. Death is said to have occurred on the date stated above, at 3:30 a.m.
The principal cause of death and related causes of importance were as follows:

Date of onset
Atelectasis left upper lobe
Other contributory causes of importance:
Bronchiectasis R.M. & Right lower lobe

Name of operation Lobectomy R.M. & R.L. Date of 5/8/39
What test confirmed diagnosis? X-ray Was there an autopsy? Yes

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

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) [Signature] M. D.
(Address) BARNES HOSPITAL

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.

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

Registered Apprentice No., working under my personal supervision.

Signed

Henry Eynock

Licensed Embalmer No. *1284*

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 this body is not embalmed, above space should be left blank.