19 1939

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 40851

Registration District No. 7084 Primary Registration District No. 200 Registrar's No. 2026

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.

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Pattonville (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Jewish Sanatorium of St. Louis (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 38 days (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis (If outside city or town limits, write "RURAL")

(d) Street No. 3652 South Jefferson Ave. (If rural, give location)

(e) If foreign born, how long in U. S. A.? 40 years

3. (a) PRINT FULL NAME AURELIA DE GROTHE 263

3. (b) If veteran, name of war

3. (c) Social Security No.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife MAX DE GROTHE (DECEASED)

6. (c) Age of husband or wife if alive not Known years

7. Birth date of deceased (Month) (Day) 1855 (Year)

8. AGE: Years About 84 Months Days If less than one day hr. min.

9. Birthplace VIENNA (City, town, or county) AUSTRIA (State or foreign country)

10. Usual occupation house wife

11. Industry or business

FATHER 12. Name unknown

13. Birthplace Austria (City, town, or county) (State or foreign country)

MOTHER 14. Maiden name unknown

15. Birthplace Austria (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. W. S. Manheimer

(b) Address 3652 S. Jefferson

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 11-19-39 (Month) (Day) (Year)

(c) Place: burial or cremation Chesed Shel Emeth

18. (a) Signature of funeral director Herman Rinaskoff

(b) Address 5216 Delmar

19. (a) NOV 19 1939 (Date received local registrar) (b) L. R. Meyer M.D. (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side) P.O. ROBERTSON, MO

MEDICAL CERTIFICATION

20. DEATH: Month November day 18 year 1939 hour 12 minute 35 P. M.

21. I hereby certify that I attended the deceased from October 12, 1939, to November 18, 1939; that I last saw her alive on November 18, 1939; and that death occurred on the date and hour stated above.

Immediate cause of death

I) Cerebral hemorrhage

Arterio sclerotic heart disease

Due to

II) hypertension

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature Arling Simon (M. D. or other) M.D.

Address JEWISH SANATORIUM Date signed 11/18/39

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

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