DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 17 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 173

173

Registration District No. 501

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH: 1003

(a) County

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

(c) Name of hospital or institution: Josephine-Heitkamp Hospital
(If not in hospital or institution, write street number or location)

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

In this community 34 Days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Overland Mo NR
(If outside city or town limits, write "RURAL")

(d) Street No. 3515 Bosswell Ave
(If rural, give location)

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

3. (a) PRINT FULL NAME Louis H. Grone

3. (b) If veteran, name war ********

3. (c) Social Security No. *******

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Catherine Grone

6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased October 20 1868 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
71	2	16	hr. min.

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

10. Usual occupation Proprietor

11. Industry or business Restaurant

FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Catherine L. Grone

(b) Address 3515 Boswell Ave Overland Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 8 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Peetz Brothers

(b) Address 3029 Lafayette Ave

19. (a) JAN 8 1940 (Date received local registrar) (b) J. Budleck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 5th year 1940 hour 2 minute 45 P. M.

21. I hereby certify that I attended the deceased from Dec. 4 1939, to Jan 5th 1940, that I last saw him alive on Jan 5th 1940, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Uremia and myocardial failure.	2 wks
Due to chronic nephritis	3 yrs
Due to chronic myocarditis coronary atery sclerosis	
Other conditions (Include pregnancy within 3 months of death)	

Major findings of operations: supra pubic cystotomy 12.16.39. chronic cystitis Benign hypertrophy of prostate

Of autopsy

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 J. M. Macnish (M. D. or other) M.D.

Address 3504 Metropolitan Bldg Date signed 1-5-40

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

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

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