

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

21253
Do not use this space.

1. PLACE OF DEATH **3**

(a) County DuChesne Registration District No. 85

(b) Township St. Joseph Mo Primary Registration District No. 1001 Registered No. 658

(c) City St. Joseph Mo (d) Street No. State Hospital #2 St.

(e) Length of residence in city or town where death occurred 60 yrs. mos. ds. (f) How long in U. S., if of foreign birth? 60 yrs. mos. ds.

2. PRINT FULL NAME August Groenke

(a) Residence, No. 1418 Dewey Ave St. Joseph Mo (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) January 4, 1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 81 5 12

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

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

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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-16-1940

22. I HEREBY CERTIFY That I attended deceased from June 10, 1940 to June 16, 1940

Last saw him alive on June 16, 1940 Death is said to have occurred on the date stated above, at 6 P m.

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

Date of onset Ind

Other contributory causes of importance:
Cerebroarteriosclerosis

Name of operation None Date of _____

What test confirmed diagnosis? None Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? no Date of injury _____, 19____

Where did injury occur? none (Specify city or town, county, and State)

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

Manner of injury None

Nature of injury _____

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

(Signed) O. Bell M. D.
(Address) State Hospital #2
St. Joseph Mo

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

FATHER 13. NAME Friedrich Groenke

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown
Germany

MOTHER 15. MAIDEN NAME Eva Gattner

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown
Germany

17. INFORMANT State Hospital #2
St. Joseph Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE burial, Mt. Auburn DATE June 18, 1940

19. FUNERAL DIRECTOR (NAME) Walter Medschoff
(ADDRESS) 1302 Faraon, St. Joseph, Missouri

20. FILED 6/18 1940 H. K. Kellbach
Local Registrar.

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..... *H H Kelly*.....

Licensed Embalmer No..... *397B*.....

P. O. Address..... *St Joseph, Va*.....

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.