

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

33775

Registration District No.

791

Primary Registration District No.

1003

Registrar's No.

8072

1. PLACE OF DEATH:

(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:
5067 Chippewa 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Georgiana M. Grebe

8. (b) If veteran, name war _____ 8. (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 Herman Grebe 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased February 12 1862
(Month) (Day) (Year)

8. AGE: Years 72 78 Months 7 Days 29 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Frank Kuhn
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace "
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature August Grebe

(b) Address 4833 Oleatha

17. (a) Burial (b) Date thereof 10-14-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hermann, Mo.

18. (a) Signature of funeral director Schumacher

(b) Address 3013 Meramec

19. (a) OCT 12 1940 (b) J. B. Brudick
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 5067 Chippewa
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 11
year 1940 hour 5.45 minute P. M.

21. I hereby certify that I attended the deceased from 1934
_____, 19____, to Oct 11, 1940
that I last saw her alive on Oct 11, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Stroke
apoplectic

Due to Art. Schumacher
Hyperextension

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) (e) Means of injury _____

23. Signature E. L. Krause (M. D. or other) _____
Address 3720 Washington Date signed _____

(Licensed Embalmer's Statement on Reverse Side)

11:00 AM / 10:00 PM

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.....

Clarence J. Rochow

Registered Apprentice No.....

working under my personal supervision.

Signed.....

Clarence J. Rochow

Licensed Embalmer No. **3093**

P. O. Address..... **3013 Meramec**

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.