

FILED APR 19 1943
Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 3249

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County: _____

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

(c) Name of hospital or institution: Park Lane Memorial Hospital
(If not in hospital or institution, write street number or location)

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

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.: 4122 Osceola Street
(If rural, give location)

(e) Citizen of foreign country? -- (Yes or No)
If yes, name country: _____

3. (a) PRINT FULL NAME: Alice Greifelt

3. (b) If veteran, name war: --

3. (c) Social Security No.: 492-09-0100

4. Sex: Female

5. Color or race: White

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

6. (b) Name of husband or wife: Oscar Greifelt

6. (c) Age of husband or wife if alive: 70 years

7. Birth date of deceased: September 18, 1877
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>65</u>	<u>6</u>	<u>18</u>	_____ hr. _____ min.

9. Birthplace: St. Louis, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation: Home

11. Industry or business: _____

12. Name: Louis Grund

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

14. Maiden name: Mary Leifredge

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

16. (a) Informant: Oscar Greifelt

(b) Address: 4122 Osceola Street

17. (a) (b) Date thereof: Burial 4 9 43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Sunset Burial Park

18. (a) Signature of funeral director: Wacker-Willis-Head Co.

(b) Address: 3634 Gravois Avenue

19. (a) APR 7 1943 (b) J. F. Bradock
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: April day: 6
year: 1943 hour: 2 minute: 45 A. M.

21. I hereby certify that I attended the deceased from 4/4/43
to 4/6/43
that I last saw him alive on 4/6/43
and that death occurred on the date and hour stated above.

Immediate cause of death: Chr. Bulbar Paralysis

Due to _____

Due to _____

Other conditions: 82!
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations: _____

Of autopsy: _____

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? _____

While at work? _____ (Specify type of place)

(c) Means of injury: _____

23. Signature: B. William Porth (M. D. or other) M.D.

Address: 5101 Delmar Bl. Date signed: 4/6/43

Duration: 690.

PHYSICIAN: _____

Underline the cause to which death should be charged statistically.

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..... *Robert Wheeler*.....
Licensed Embalmer No. *2178*.....
P. O. Address *Soledad 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, fact should be so stated above.