

S. No. 2
M-5-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

UNITED STATES HEALTH DEPARTMENT
STANDARD CERTIFICATE OF DEATH
1003

State File No. 366
Registrar's No. 655

20047
FILED FEB 1 1944
Registration District No. 318

Primary Registration District No. _____

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

1. PLACE OF DEATH:
(a) County St. Louis, Mo.
(b) City or town _____
(c) Name of hospital or institution: St. Louis City Hospital-Max C. Starkloff Memorial
(d) Length of stay: In hospital or institution 1 Mo-11 days
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town St. Louis
(d) Street No. 1522 S. 3rd St.
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Gus Grieser
3. (b) If veteran, name war no 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased October 15, 1880
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
63 3 4 _____ hr. _____ min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation Laborer

11. Industry or business _____
12. Name Frank Grieser
13. Birthplace Germany
14. Maiden name Katherine Meinhardt
15. Birthplace Germany

16. (a) Informant Mrs. Elizabeth Lopp
(b) Address 7125 Pennsylvania Ave.

17. (a) Burial (b) Date thereof Jan 22, 1944
(c) Place: burial or cremation New St. Marcus Cm.

18. (a) Signature of funeral director Weick Bros.
(b) Address 2201 S. Grand Bl.
19. (a) JAN 21 1944 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 19th
year 1944 hour 2:00 minute _____ P. M.
21. I hereby certify that I attended the deceased from December 8th
1944 to January 19th 1944
that I last saw HEM alive on January 19th 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar pneumonia
Due to _____
Due to _____
Other conditions Cerebral arteriosclerosis
(Include pregnancy within 3 months of death)

PHYSICIAN _____
Major findings: Of operations _____
Of autopsy Refused

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) (e) Means of injury _____
23. Signature Fay Finley (M. D. or other) M.D.
Address 15 N. Lafayette Date signed 1/19/44

(Licensed Embalmer's Statement on Reverse Side)

644

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.....

John J. Patten
3880

Licensed Embalmer No.....

P. O. Address.....

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.