

FILED JAN 19 1944

Registration District No. 37

Primary Registration District No. 3063

Registrar's No. 37

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

1. PLACE OF DEATH:

(a) County ST. LOUIS

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

(c) Name of hospital or institution: ST. LOUIS COUNTY HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 days
(Specify whether years, months or days)

In this community 1 YR. 6 MO.

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JEFFERSON

(c) City or town HILLSBOROUGH
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) RURAL

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME ERNST GROSS

3. (b) If veteran, name war NO.

3. (c) Social Security No. NONE

4. Sex MALE 5. Color or race WHITE

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

6. (b) Name of husband or wife Hattie

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

7. Birth date of deceased MARCH 19 - 1859
(Month) (Day) (Year)

8. AGE: Years 84 Months 08 Days 28 If less than one day _____ hr. _____ min.

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

10. Usual occupation FARMER

11. Industry or business _____

12. Name WILLIAM GROSS

13. Birthplace HILLERSDORF GERMANY
(City, town, or county) (State or foreign country)

14. Maiden name ERNESTINE BISCHOFF

15. Birthplace HILLERSDORF GERMANY
(City, town, or county) (State or foreign country)

16. (a) Informant Thomas W. Gross

(b) Address 476 W. Lockwood

17. (a) BURIAL (b) Date thereof JAN 7 - 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation VALHALLA CEM

18. (a) Signature of funeral director Parker and e

(b) Address WEBSTER GROVES MO.

19. (a) JAN 8 - 1944 (b) E. D. McSarran, M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1-5-44 day _____ year _____ hour 5:00 minute 9 P. M.

21. I hereby certify that I attended the deceased from 12-30-43 to 1-5-44, 19____; that I last saw him alive on 1-5-44, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia

Sulfathiazole kidney block + uremia

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death)

Duration

2 wks

2 days

Major findings: Of operations _____

Of autopsy Bronchopneumonia 107
Sulfathiazole kidney block

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? _____

While at work? _____ (Specify type of work) (e) Means of injury _____

23. Signature James H. Owen (M. D. or other) M.D.

Address 1607 S. Brentwood Date signed 1-6-44

33711 N.

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 *W. B. Aldrich*
Licensed Embalmer No. 1332
P. O. Address *Deebley Groves*

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.