

S. No. 2
M-5-43
7. 5-17-39
I X36671

FILED MAR 1 1944
Registration District No. **318**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County.....

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

(c) Name of hospital or institution:
St. Louis City Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1 Mo.**
(Specify whether years, months or days)

In this community **40 Years**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **JOSEPH GROSS**

3. (b) If veteran, name war **None**

3. (c) Social Security No. **None**

4. Sex **Male**

5. Color or race **White**

6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Caroline**

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

7. Birth date of deceased **Dec 20 1871**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
72	1	25hr.min.

9. Birthplace **Austria**
(City, town, or county) (State or foreign country)

10. Usual occupation **Molder**

11. Industry or business.....

MOTHER, FATHER { 12. Name **John Gross**

13. Birthplace **Austria**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

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

16. (a) Informant **Frank Gross**

(b) Address **2800 A Arlington Ave**

17. (c) **Burial** (Burial, cremation, or removal) (b) Date thereof **2 / 18 / 44**
(Month) (Day) (Year)

(c) Place: burial or cremation **Calvary**

18. (a) Signature of funeral director **A.W. McLaughlin**

(b) Address **2301 Lafayette Ave**

19. (a) **FEB 18 1944** (b) **J. H. Freden**
(Date received local health officer's report) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000 17**

(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL") **96**

(d) Street No. **2800 A Arlington Ave**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country..... **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **15th**
year **1944** hour **2:10** minute **A.M.**

21. I hereby certify that I attended the deceased from **Jan. 15th**
....., 19**44** to **Feb. 15th**....., 19**44**
that I last saw him alive on **Feb. 15th**....., 19**44**
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Cerebral thrombosis

Due to.....

Due to..... **83**

Other conditions **general arteriosclerosis**
(Include pregnancy within 6 months of death)

Major findings:
Of operations.....

Of autopsy **Refused**

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 place)
..... (c) Means of injury.....

23. Signature **Frank Gross** (M. D. or other) **Dr. H. S.**
Address **1525 Lafayette** Date signed **2/15/44**

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 L R Cooper

Licensed Embalmer No. 3633

P. O. Address. 2317 Lafayette

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.