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-5-43
-17-39
X36671

FILED APR 13 1944
318

Registration District No. _____ Primary Registration District No. **1003**

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 **2 days**
(Specify whether
 In this community **7 Years**
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. **1240 South 9th, St.**
(If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **John Grenia**

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 **Married**

6. (b) Name of husband or wife **Pearl** 6. (c) Age of husband or wife if alive **40 years**

7. Birth date of deceased **May 17 1902**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

41 **10** **16** hr. _____ min.

9. Birthplace **Washington County Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name **Joe Grenia**

13. Birthplace **Washington County Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Hugher**

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

16. (a) Informant **Pearl Grenia**

(b) Address **1240 South 9th, St.**

17. (a) **Burial** (b) Date thereof **4/8/44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Matthews 48-44**

18. (a) Signature of funeral director **A. W. No Laughlin**

(b) Address **2301 Lafayette Ave.**

19. (a) **APR 6 1944** (b) **J. F. Brueck**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **3rd**
 year **1944** hour **7:00** minute **A.** M.

21. I hereby certify that I attended the deceased from **April 1st**
 _____, 19 **44** to **April 3rd**, 19 **44**
 that I last saw him alive on **April 3rd**, 19 **44**
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Cirrhosis of the liver

Due to _____

Due to _____

Other conditions **Chronic alcoholism**
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
 Of operations _____

Of autopsy **Refused**

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 Schuler** (M. D. or other) **no**
2515 Lafayette Date signed **4/3/44**

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

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.