

FILED JUL 31 1944

State File No.

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 1578

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Baden Station
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Halls Ferry Memorial Hosp.
(If not in hospital or institution, write street number or location) 0
(d) Length of stay: In hospital or institution. _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County St. Louis 96
(c) City or town Baden Station 0
(If outside city or town limits, write "RURAL")
(d) Street No. Halls Ferry Memorial Hospital 0
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____ 0

3. (a) PRINT FULL NAME Theresa M. Grubb
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 22
year 1944 hour 6 minute 45 A.M.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Edward Grubb 6. (c) Age of husband or wife if _____ years
7. Birth date of deceased Apr. ? 1871
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June 15, 1944 to July 22, 1944
that I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

8. AGE: Years 73 Months 3 Days ? If less than one day _____ hr. _____ min.
9. Birthplace St. Louis Mo. 0
(City, town, or county) (State or foreign country)

Immediate cause of death Chronic Myocarditis
Due to _____
Due to 93A
Other conditions (Include pregnancy within 3 months of death) _____

10. Usual occupation Home
11. Industry or business _____
12. Name Unknown Griffin
13. Birthplace Unknown Unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown Unknown 9
(City, town, or county) (State or foreign country)

Major findings: Of operations _____
Of autopsy No
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant J. E. Helbig
(b) Address 8612 Oiole Ave.
17. (a) Burial (b) Date thereof 7-24-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Valhalla Cem.
18. (a) Signature of funeral director Drehmann-Harral
(b) Address 1905 Union Blvd.
19. (a) JUL 25 1944 (b) E. D. McAvran, M.D.
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) No
(b) Date of occurrence No
(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? _____
(Specify type of place) _____
While at work? _____ (e) Means of injury _____
23. Signature Hellie Bleaver (M. D. or other) _____
Address R. 9, 92 - Maryland Date signed 8-23-44

707

(Licensed Embalmer's Statement on Reverse Side)

44

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

96000

Mr. Willie Sherman

4981 Maryland

PO Box 1 - 220 R T 6

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 *Warren A Carver*

Licensed Embalmer No. *3534*

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.