

V. S. No. 2
FORM—8-43
Rev. 5-17-39
I X37823

7763

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAR 16 1945

2234

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. _____

1. PLACE OF DEATH:

(a) County _____

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

(c) Name of hospital or institution:
3519 S. Spring Ave.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED: **000**

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

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

(d) Street No. **3519 S. Spring Ave.**
(If rural, give location)

(e) Citizen of foreign country? **0** (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME **Elizabeth Gruenewald**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widow**

6. (b) Name of husband or wife **Oswald** 6. (c) Age of husband or wife if alive **4** years **1854**

7. Birth date of deceased: **Dec.** **4** **1854**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Mar.** day **7**
year **1945** hour **8** minute **00** A.M.

21. I hereby certify that I attended the deceased from **March 5**
1945 to **March 7**, **1945**,
that I last saw her alive on **March 7**, **1945**
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	90	3	3	hr. _____ min. _____

Immediate cause of death: **Coronary Thrombus** **1 hr**

Due to **Myocarditis** **1 yr**

Due to **Arterio-sclerosis** **1 yr**

Other conditions (Include pregnancy within 3 months of death) _____

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

10. Usual occupation: **Home**

Major findings: _____

Of operations: **1**

Of autopsy: _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

11. Industry or business _____

12. Name **Unkown**

13. Birthplace **Unknown**
(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 **Bernice Wesling**
(b) Address **3716 Loughborough**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

17. (a) **Burial** (b) Date thereof **Mar. 10, 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Paul's Churchyard**

(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? _____

18. (a) Signature of funeral director **Wacker Helderle**
3634 Gravois Ave.

(b) Address _____

19. (a) **MAR 9 1945** (b) **J. F. Brueck**
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

(c) Means of injury _____

23. Signature **W. Simpson** (M. D. or other **M.D.**)
Address **3739 Gravois** Date signed **3/8/45**

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

0
7
9

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..... *Robert Wheeler*

Licensed Embalmer No..... *2128*

P. O. Address..... *St Louis Mo*

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.