

FILED MAY 12 1945 **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2601 North Sarah St., /
(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:

(a) State Missouri (b) County 000
(c) City or town St. Louis /
(If outside city or town limits, write "RURAL") /
(d) Street No. 2601 North Sarah St., / 11
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Mary Rebecca Grimmer

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 Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased February 14th 1872
(Month) (Day) (Year)

8. AGE: Years 73 Months 2 Days 10 If less than one day hr. _____ min. _____

9. Birthplace Cincinnati, Ohio /
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name Thomas Grimmer
13. Birthplace Ireland /
(City, town, or county) (State or foreign country)
14. Maiden name Mary O'Neill
15. Birthplace Ireland /
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Peter P. Higgins-Sister

(b) Address 2601 North Sarah Street,

17. (a) burial (b) Date thereof 4-26-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Int. Calvary Cemetery

18. (a) Signature of funeral director Sullivan Brothers,

(b) Address 2849 North Euclid Avenue

19. (a) APR 24 1945 J. F. Bredak
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 24th
year 1945 hour 8:00 minute A. M.

21. I hereby certify that I attended the deceased from April 4
1945 to April 24 1945
that I last saw h. al alive on April 23 1945
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Cerebral thrombosis
Complications of left-sided stroke
1. Hypertension
Due to _____
Due to arterio sclerosis of
arteries
Other conditions _____
(Include pregnancy within 3 months of death)

Duration
1 day
10 years

Major findings:
Of operations _____
Of autopsy _____
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?

(Specify type of place)
While at work? _____ Means of injury 0
23. Signature A. M. Koell (M. D. or other)
Address 2416 2nd Grand Date signed 4/24/45

Dr. A. M. Krall
2416 No. Grand Ave.,
Fr. 4270

Today between 3-4 P.M.

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 L. Drinkman
Licensed Embalmer No. *3553*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *may*

Registration District No. *318*

Primary Registration District No. *1003*

Registrar's No. *3645*

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:
(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)

3. (a) PRINT FULL NAME *Mary R. Grimmer*
 3. (b) If veteran, name war.....
 3. (c) Social Security No.....

4. Sex *F* 5. Color or race *w*
 6. (a) Single, widowed, married, divorced *5*
 6. (b) Name of husband or wife.....
 6. (c) Age of husband or wife if alive.....
 7. Birth date of deceased *Feb.* (Month) *1945* (Day) *19* (Year)

8. AGE: Years *73* Months Days If less than one day
 .hr. min.

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

10. Usual occupation *Suppl.*
(City, town, or county) (State or foreign country)

11. Industry or business

MOTHER FATHER { 12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) *MAY 18 1945* (b) *J. F. Bredek*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
 (c) City or town.....
(If outside city or town limits, write "RURAL")
 (d) Street No.....
(If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *May* year *1945* hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to....., 19.....
 that I last saw h..... alive on....., 19.....
 and that death occurred on the date and hour stated above.
 Immediate cause of death.....

Duration

Due to.....
 Due to.....

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

Major findings:
 Of operations.....
 Of autopsy.....

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..... (M. D. or other).....
 Address..... Date signed.....

SUPPLEMENTARY

11285