

FILED JUN 9 1945

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4842

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:  
2041 East Alice Ave  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None  
(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. 2041 E. Alice Ave  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_  
(Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Fredrich Grote

3. (b) If veteran, name war World #1

3. (c) Social Security No. 494-09-3705

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 30, year 1945 hour 1:50 AM minute \_\_\_\_\_ M.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife E. Grote nee Miller 6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased February 16, 1893  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from NOV 1, 1944 to May 30, 1945  
that I last saw him alive on May 29, 1945  
and that death occurred on the date and hour stated above.

8. AGE: Years 52 Months 3 Days 14 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death: Cerebral hemorrhage Duration 36 hrs

9. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

Due to Hypertension

Due to Arterio Sclerosis

10. Usual occupation Mechanical Draftsman

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name C. August Grote

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

14. Maiden name Josephine Plass

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

Major findings: 8/2

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs Clara E. Grote

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

(b) Address 2041 E. Alice Ave

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

17. (a) Burial (b) Date thereof 6/2/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(b) Date of occurrence \_\_\_\_\_

(c) Place: burial or cremation Bellefontaine Cemetery

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

18. (a) Signature of funeral director Math Hermann & Son

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

(b) Address 2161 East Fair Ave

While at work? \_\_\_\_\_ (Specify type of place) (c) Manner of injury \_\_\_\_\_

19. (a) MAY 31 1945 (b) J. F. Bredick  
(Date received local registrar) (Registrar's signature)

23. Signature Ray O. ... (M. D. or other) MD  
Address 4350 ... Date signed 7/21/45

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

NOV 15 1945

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 *William J. Burkhead*

Licensed Embalmer No. *21105*

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.