

State File No. \_\_\_\_\_  
Registrar's No. 6723

FILED AUG 3 1945  
Registration District No. 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

(c) Name of hospital or institution: St. Johns Hospt.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 Mos 24 Days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

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

(d) Street No. 8637 Litzinger Rd.  
(If rural, give location)

(e) Citizen of foreign country? / (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Charleen Sharon Gross

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 0

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Mar. 4th. 1945.  
(Month) (Day) (Year)

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

4	24		
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hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER {

12. Name Wm. Gross

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

14. Maiden name Charlotte Givens

15. Birthplace New York City. N.Y.  
(City, town, or county) (State or foreign country)

16. (a) Informant Wm. Gross

(b) Address 8637 Litzinger Rd.

17. (a) Burial (b) Date thereof 7/28/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Picker Cem.

18. (a) Signature of funeral director Jay B. Smith

(b) Address 7456 Manchester, Maplewood 17 Mo.

19. (a) JUL 27 1945 (b) J. F. Bredeek  
(Date received local health certificate) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 28  
year 1945 hour 9 minute 25AA M.

21. I hereby certify that I attended the deceased from March 4th, 1945, to July 28, 1945  
that I last saw her alive on July 13, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death congenital Spina Bifida with Hydrocephalus

Duration 4 mos

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

Major findings: 157  
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)

(e) Means of injury D

23. Signature Michael Dulick (M. D. or other) \_\_\_\_\_  
Address Brentwood, Mo Date signed 7-28-45

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**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.

*No Embalmer*  
Signed *[Signature]*

Licensed Embalmer No. *3154*

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.**