No. 2
—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 34605

FILED OCT 27 1945

Registration District No. 317 Primary Registration District No. 3063 Registrar's No. 2458

1. PLACE OF DEATH:
(a) County St Louis County
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Louis County Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 13 days (Specify whether
In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St Louis 96
(c) City or town River Grove Gardens
(If outside city or town limits, write "RURAL")
(d) Street No. 141 Coburg
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) 1
If yes, name country

3. (a) PRINT FULL NAME Richard Grenzeback
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased 9 (Month) 13 (Day) 1928 (Year)

8. AGE: Years 17 Months 1 Days 12 If less than one day hr. min.

9. Birthplace River Gardens (City, town, or county) Mo (State or foreign country)
10. Usual occupation Student
11. Industry or business —
FATHER
12. Name Archie Grenzeback
13. Birthplace St Louis (City, town, or county) Mo (State or foreign country)
MOTHER
14. Maiden name Lillian McDonnell
15. Birthplace St Louis (City, town, or county) Mo (State or foreign country)
16. (a) Informant Mother
(b) Address 141 Coburg R.G. Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 29, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation New Bethlehem Cemetery
18. (a) Signature of funeral director Nath Hermann & Son
(b) Address 2161 E Fair Av
19. (a) 10-26-45 (Date received local registrar) (b) E. G. McGavran MD (Registrar's signature) MSA

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 25 year 1945 hour 7 minute 50 A.M.
21. I hereby certify that I attended the deceased from 10 12, 1945, to 10-25, 1945, that I last saw him alive on 10-25, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pulpefaction of spinal cord due to compression fracture of	
~~Due to~~ 7th cervical vertebra.	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy Pulpefaction of spinal cord.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) Accident 96
(b) Date of occurrence 10-12-45
(c) Where did injury occur? Hallsferry & Chambers Rd, St Louis Co. Mo. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Highway (Specify type of place)
While at work? NO (e) Means of injury Auto Acc.
23. Signature John T. Farrar (M.D. or other)
Address 601 Brentwood Clayton Date signed 10/26/45

(Licensed Embalmer's Statement on Reverse Side)

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 Gustav W. Dietsch

Licensed Embalmer No. #329

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.

S. No. 2B
M—3-45
1 X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 3X605

Registration District No. 317 Primary Registration District No. 3063 Registrar's No. 2X58

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town Clayton
(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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME Richard Grenzebach
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Sept 13 1944 (Month) (Day) (Year)
8. AGE: Years 17 Months 1 Days If less than one day hr. min.
9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation
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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct Day 22 year 1945 hour minute M.
21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Acute compression of spinal cord by fracture of cervical vertebrae	13 d.
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) accident Auto
(b) Date of occurrence 10-12-46
(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 Auto-accid.
23. Signature W. M. W. Canto (M. D. or other) MD
Address Date signed

SUPPLEMENTARY