

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

**FILED** JAN 5 1945  
318

1003

Registration District No. \_\_\_\_\_ Primary Registration District 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:  
4114 Arsenal 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

3. (a) PRINT FULL NAME Elizabeth M Groll

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. None

4. Sex Female /

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

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

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

7. Birth date of deceased: June 23 1861  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>84</u>	<u>5</u>	<u>27</u>	_____ hr. _____ min.

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

10. Usual occupation None

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

12. Name Andrew Oppermann

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

14. Maiden name Helen Bakers

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

16. (a) Informant Henry Groll

(b) Address 4114 Arsenal St.

17. (a) Burial Old St. Peter & Paul Cem  
(Burial, cremation, or removal)

(b) Date thereof Dec. 22 1945  
(Month) (Day) (Year)

18. (a) Signature of funeral director Wm. J. Robert L & U Co.

(b) Address 1905 S Gram Blvd.

19. (a) DEC 21 1945  
(Date received local Registrar)

J. F. Bredash  
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

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

(d) Street No. 4114 Arsenal St.  
(If rural, give location)

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 20 th  
year 1945 hour 12 minute 55 AM.

21. I hereby certify that I attended the deceased from Nov. 19<sup>th</sup>  
1945, to Dec. 20<sup>th</sup> 1945  
that I last saw her alive on Dec. 20<sup>th</sup> 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Chronic Myocardial Disease and Arterio-  
Sclerosis

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

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

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

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

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 \_\_\_\_\_

23. Signature Paul B. Webb M.D. (M. D. or other)

Address 1915<sup>th</sup> Sidney Date signed 12/21/45

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

MOTHER FATHER

Duration

2 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

**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.....

*Rex Campbell*

Licensed Embalmer No. *3881*

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.**