

FILED DEC 24 1946

Registration District No. 318Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St. Louis, Missouri
 (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: The City Infirmary Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution May 1, 1945
to 12-14, 1946 (Specify whether
 years, months or days)

3. (a) PRINT FULL NAME John D. Granneman

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race W
 6. (a) Single, widowed, married, divorced Widower
 6. (c) Age of husband or wife if alive 35 years
 7. Birth date of deceased May 18 1866
 (Month) (Day) (Year)

8. AGE: Years 80 Months 6 Days 26 If less than one day
 hr. min.

9. Birthplace St. Louis, Missouri (City, town, or county) (State or foreign country)10. Usual occupation nil

11. Industry or business _____

12. Name Louis Granneman13. Birthplace Germany (City, town, or county) (State or foreign country)14. Maiden name Anna Maleria15. Birthplace Germany (City, town, or county) (State or foreign country)16. (a) Informant The City Infirmary Records(b) Address 5800 Arsenal Street17. (a) Burial (b) Date thereof Dec 17-46
 (Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation New Pader Cem18. (a) Signature of funeral director Thos Kutis(b) Address 2906 3rd Ave19. (a) DEC 15 1946 (b) J. F. Brudeck
 (Date received local registrar) (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. 5800 Arsenal Street
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 14,
 year 1946 hour 7 minute 20 AM.21. I hereby certify that I attended the deceased from July 2,
 _____, 1945 to December 14, 1946;
 that I last saw him alive on December 14, 1946
 and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Due to Arteriosclerotic heart disease,
 Hypertrophic Arthritis.

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 sta-
 tistically.

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 Palmer Rasmus Bowditch (M. D. 12-14-46)
 Address 5800 Arsenal Street Date signed 12-14-46

FEB 3 1947

FEB 6 1947

J

PROCEMI

STATE OF

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 *Les J. Budd*

Licensed Embalmer No. *0489*

P. O. Address *St Louis mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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. *Jan*

Registration District No. *318*

Primary Registration District No. *1003*

Registrar's No. *110728*

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 *John D. Shaneman*

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 *wid*

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive.....

7. Birth date of deceased *May 18*
(Month) (Day) (Year)

8. AGE: Years *80* Months Days *mo* (if less than one day) min.

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

10. Usual occupation.....

11. Industry or business.....

MOYER 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) *J. F. Brebeck*
(Registrar's signature) *1947*

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 *Dec* year *1946* hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to....., 19.....;

that I last saw him/her 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) (e) Means of injury.....

23. Signature..... (M. D. or other).....

Date signed.....

SUPPLEMENTARY

42426