

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 11 1947

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3763

State File No.

Registration District No. 362

Primary Registration District No. 4235

Registrar's No. 1

1. PLACE OF DEATH:

(a) County Warren
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Normandy
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 7432 Augusta Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME

George Gruenewald

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 Married
6. (b) Name of husband or wife Anna Gruenewald
6. (c) Age of husband or wife if alive 68 years
7. Birth date of deceased October 31 1870
(Month) (Day) (Year)

8. AGE: Years 76 Months 2 Days 29 If less than one day hr. min.

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

10. Usual occupation Retired
Louis

11. Industry or business St. Screw & Bolt Co.

12. Name Ferdinand Gruenewald

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

14. Maiden name Caroline Siedler

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

16. (a) Informant Anna Gruenewald

(b) Address 7432 Augusta Ave

17. (a) Burial (b) Date thereof Feb. 1 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine Cem

18. (a) Signature of funeral director Calvin F Feutz

(b) Address 4828 Nat Bridge Blvd

19. (a) 1-29-47 (b) Mrs. Fred Moray
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 29
year 1947 hour 9 minute 10.2 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.

Immediate cause of death. Cerebral embolism

Due to. Cerebral embolism

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

Duration
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?
(Specify type of place)

While at work?.....
(c). Means of injury.....

23. Signature D.P. H. Knapp (M. D. or other)
Address Warrenton Mo Date signed Jan 29 1947

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

MOTHER FATHER

378

(Licensed Embalmer's Statement on Reverse Side)

MAR 6 1947

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed

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 *John A. Mlinar*
Licensed Embalmer No. *4186*
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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7-21
Registrar's No. 1

Registration District No. 362

Primary Registration District No. 6235

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

1. PLACE OF DEATH:

(a) County Warren
(b) City or town Rural - Parkway Twp
(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 _____ (Specify whether _____)
years, months or days

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 George S. Greenwald
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 m
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct 31 (Month) (Day) (Year)

8. AGE: Years 76 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)
(Data received local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____
year 1947 (hour) _____ (minute) _____ M.
21. I hereby certify that I attended the deceased from _____, 19____;
to _____, 19____;
that I last saw him _____
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) _____

Address _____ Date signed _____

SUPPLEMENTARY

S-3763