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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 14 1947
#10846

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6344

State File No.

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **2389**

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:
St. Louis City Hospital - Max C. Starkloff
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 1/2 days
(Specify whether years, months or days)
In this community 25 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County oas
(c) City or town St. Louis Y317
(If outside city or town limits, write "RURAL")
(d) Street No. 1548 South Broadway
Memorial (If rural, give location) 9
(e) Citizen of foreign country? no (Yes or No) 0
If yes, name country.....

3. (a) PRINT FULL NAME GEORGE GREBE

3. (b) If veteran, name war nil 3. (c) Social Security No. none

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W 2

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

7. Birth date of deceased March 11, 1873
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
73 11 24 hr. min.

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

10. Usual occupation Laborer

11. Industry or business retired

12. Name John Grebe

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

14. Maiden name Effie Matthews

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

16. (a) Informant Minnie Lockhart

(b) Address 1821a Lami Street

17. (a) burial (b) Date thereof 3-8-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews Cemetery

18. (a) Signature of funeral director A.W. McLaughlin

(b) Address 2301 Lafayette Avenue

19. (a) MAR 8 1947 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 5th
year 1947 hour 1:45 minute P M.

21. I hereby certify that I attended the deceased from 3/3/47
....., 19....., to 3/5/47, 19.....;
that I last saw him alive on 3/5/47, 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho pneumonia Duration ?

Due to Exposure & Malnutrition

Due to Extreme Exposure

Other condition Arteriosclerotic Heart Disease

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) 0
Means of injury 0
23. Signature [Signature] (M. D. or other) MD
Address 1515 Lafayette Date signed 3/5/47

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

OK

6803

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 *R W Cooper*

Licensed Embalmer No. *6730*

P. O. Address *Bel Fayette Ave*

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.