

No. 300
-10-47
5-17-39
I 3906

#83352
FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED MAY 11 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

1414141
State File No. _____
Registrar's No. 4094

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County City Hospital
(b) City or town St. Louis, Mo.
(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 7 weeks
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 3706 California 9
Memorial (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME EMMA GRUEN
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 29th
year 1948 hour 1 minute 45 A.M.
21. I hereby certify that I attended the deceased from 3/8/48
19____ to April 29th, 1948 19____
that I last saw her alive on April 29th, 1948 19____
and that death occurred on the date and hour stated above.

4. Sex F 5. Color or race W
6. (a) ~~Single~~ widowed, ~~married~~ divorced
6. (b) Name of husband or wife Chas. Gruen 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Aug 15 1876
(Month) (Day) (Year)

Immediate cause of death
Respiratory
Failure
Broncho
Pneumonia
Cancer of
Gall bladder
with metastases
Duration _____

8. AGE: Years 71 Months 8 Days 14
If less than one day hr. _____ min. _____
9. Birthplace St. Louis, Mo. (City, town, or county) (State or foreign country)
10. Usual occupation H. W.

Other conditions (Including pregnancy within 3 months of death) _____
Major findings:
Of operations _____
Of autopsy Hof
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

11. Industry or business SEBASTION CLOEDY
12. Name SEBASTION CLOEDY #
13. Birthplace GER. #
(City, town, or county) (State or foreign country)
14. Maiden name LIZZIE FULLARD
15. Birthplace ST. LOUIS MO
(City, town, or county) (State or foreign country)

16. (a) Informant CHAS GRUEN
(b) Address 3706 CALIFORNIA
17. (a) ST. MATTHEWS (b) Date thereof MAY 1, 48
(Burial) (Month) (Day) (Year)
(c) Place: burial or cremation ST. MATTHEWS CEM.
18. (a) Signature of funeral director Wm Schuyler
(b) Address 3018 Meramec St
19. (a) APR 30 1948 (Date received local registrar)
J. F. Braden (Registrar's signature)

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)
Signature 1515 Lafayette (M. D. or other)
Roscoe Morton 4/29/48
Address _____ Day _____

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

MOTHER FATHER

Embalmer shortage cert filed

APR 30 1948

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.....

Licensed Embalmer No.....

P. O. Address.....

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.