

FILED JAN 6 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41179

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 3058 Registrar's No. 247

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Charles</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Charles</u>	
c. LENGTH OF STAY (in this place) <u>unknown</u>		d. STREET ADDRESS (If rural, give location) <u>1101 North Third Street</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph Hospital (i)</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Frank</u> b. (Middle) <u>—</u> c. (Last) <u>Grothe</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>December 22-1948</u>
5. SEX <u>Male (i)</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept 11-1880</u>
9. AGE (In years last birthday) <u>68</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>A.C.&amp;F. St. Charles</u>	11. BIRTHPLACE (State or foreign country) <u>Josephville, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13a. FATHER'S NAME <u>Anton Grothe</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Stohman</u>	14. NAME OF HUSBAND OR WIFE <u>Dola (Griesbauer) Grothe</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>488-12-7897</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Dola Grothe-St. Charles, Mo.</u> ADDRESS _____	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. <u>9/10</u>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Embolism</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Coronary occlusion</u> DUE TO (c) <u>Arteriosclerosis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>St. Charles, St. Charles, Mo</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <u>Sept 10</u> 19 <u>48</u> , to <u>Dec. 22</u> , 19 <u>48</u> that I last saw the deceased alive on <u>Dec. 22</u> , 19 <u>48</u> and that death occurred at <u>3 A. m.</u> , from the causes and on the date stated above. <u>U</u>			
23a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>Miss</u>		23b. ADDRESS <u>St. Charles, Mo</u>	23c. DATE SIGNED <u>12-24-48</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	24b. DATE <u>Dec 27-1948</u>	24c. NAME OF CEMETERY <u>St. Charles Borromeo</u>	24d. LOCATION (City, town, or county) (State) <u>St. Charles Missouri</u>
DATE REC'D BY LOCAL REG. <u>12/27/48</u>	REGISTRAR'S SIGNATURE <u>Lawrence Hamilton</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>H.P. Gallmeyer &amp; Sons Co</u> ADDRESS <u>800 N. 2nd St. Charles, Mo.</u>	

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

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RECEIVED  
District Health Officer No. 9,  
District File Number JAN 4 1949  
Date Filed

JAN 7 1949

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_  
Student Embalmer

Signed Joseph I. Landolt  
Licensed Embalmer No. 4189

P. O. Address St. Charles

**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.