

FILED FEB 2 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2817

718

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION: Little Sisters of Poor		d. STREET ADDRESS (If rural, give location) 3400 S. Grand Blvd.	

3. NAME OF DECEASED (Type or Print) Grace	a. (First) <i>Grace</i>	b. (Middle)	c. (Last) Hoss	4. DATE OF DEATH (Month) (Day) (Year) January 24, 1949
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH December 23, 1878	9. AGE (In years last birthday) 70	10. MONTHS 1	11. YEAR 1	12. HOURS 1	13. MINUTES 1
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Tamaro, Illinois	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME William Waatts	13b. MOTHER'S MAIDEN NAME Susan ?	14. NAME OF HUSBAND OR WIFE George Hoss
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Sister Theresa	ADDRESS 3400 S. Grand Blvd.
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 17 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Cerebral Haemorrhage</i>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Arterio Sclerosis</i> DUE TO (c) <i>Hypertension</i>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>444A 8300</i>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from *Jan 20*, 19*49*, to *Jan 24*, 19*49*, that I last saw the deceased alive on *Jan 22*, 19*49*, and that death occurred at _____ m. from the causes and on the date stated above.

22a. SIGNATURE <i>John H. Gebken</i>	(Degree or title)	22b. ADDRESS <i>607 N. Grand</i>	22c. DATE SIGNED <i>04/19</i>
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23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE January 26, 1949	23c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Mo.
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DATE REC'D BY LOCAL REG. JAN 24 1949	REGISTRAR'S SIGNATURE <i>J. B. Foster</i>	25. FUNERAL DIRECTOR'S SIGNATURE John H. Gebken Sons Und. Co.	ADDRESS 2630 Gravois Ave.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.

Student
Student Embalmer

Signed Robert T. Gebken

Licensed Embalmer No. 4144

P. O. Address 2630 Gravois 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.