0.300
0.48

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUL 15 1949

State File No. 21092

BIRTH NO. 44810-49 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 5938

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) De Paul Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY aaa
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis 17
d. STREET ADDRESS (If rural, give location) 2623 Minnesota Ave. 17 0

3. NAME OF DECEASED (Type or Print)
a. (First) Grace Marie
b. (Middle)
c. (Last) Grill

4. DATE OF DEATH (Month) July (Day) 6, (Year) 1949

5. SEX Female 1
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single 0
8. DATE OF BIRTH July 5, 1949
9. AGE (In years last birthday) IF UNDER 1 YEAR Months 1 Days 13 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) St. Louis Mo. 0
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME Carl Grill
13b. MOTHER'S MAIDEN NAME Grace Julianna Grill
14. NAME OF HUSBAND OR WIFE

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 Carl Grill ADDRESS 2623 Minnesota Ave.

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Atelectasis

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) ? Aspiration

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: Birth

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

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) 161 a

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 7620

22. *I hereby certify that I attended the deceased from* 7/5, 1949, *to* 7/6, 1949 *that I last saw the deceased alive on* 7/6, 1949, *and that death occurred at* 9 PM. *m., from the causes and on the date stated above.*

23a. SIGNATURE Jackson Eb (Degree or title) MD 0
23b. ADDRESS 734 Mo Theatre Bldg
23c. DATE SIGNED 7/7/49

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7/7/49
24c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery
24d. LOCATION (City, town, or county) (State) St. Louis County MO.

DATE REC'D BY LOCAL REG. JUL 7 1949
REGISTRAR'S SIGNATURE J B Lasater
25. FUNERAL DIRECTOR'S SIGNATURE John H. Gebken Sons Und. Co. ADDRESS

(Licensed Embalmer's Statement on Reverse Side)

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 Robert F. Gebken

Signed.....
Student Embalmer

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 wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.