

FILED AUG 13 1949
30220

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24844

State File No. 6801

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 Mo. b. COUNTY 02			
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis, Mo.		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis,			
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.				d. STREET ADDRESS (If rural, give location) 25 708 A PARK			
3. NAME OF DECEASED (Type or Print)		a. (First) JUDY		b. (Middle) ANN		c. (Last) GRIMM	
4. DATE OF DEATH August 3rd, 1949		5. SEX FEM		6. COLOR OR RACE Wh.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	
8. DATE OF BIRTH 4-28-44		9. AGE (In years last birthday) 5 YRS		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NIL		11. BIRTHPLACE (State or foreign country) St. Louis Mo. 0	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME WILLIAM GRIMM		13b. MOTHER'S MAIDEN NAME OPAL BROWN		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 ADDRESS WILLIAM GRIMM 708a PARK			
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.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Polio myeliter spinal & bulbospinal				INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c)					
		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 type="checkbox"/>	
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) 36			
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? ! 0800			
22. I hereby certify that I attended the deceased from 7/29/49 , 19___, to 8/3/49 , 19___, that I last saw the deceased alive on 8/3/49 , 19___, and that death occurred at 4:40pm. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Joseph J. Mueller (J. M. D.)				23b. ADDRESS 1515 Lafayette Ave.,		23c. DATE SIGNED 8/4/49	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 8-6-49		24c. NAME OF CEMETERY OR CREMATORY NEW ST. MARCUS		24d. LOCATION (City, town, or county) (State) St. Louis. Mo	
DATE REC'D BY LOCAL REG. AUG 5 1949		REGISTRAR'S SIGNATURE J. B. Foster		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C. J. Schnur 3125 Lafayette			

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

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 *Joseph B. Hollman*

Licensed Embalmer No. *41014*

P. O. Address *3125 Lakewood*

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.