

FILED FEB 24 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 6264

1053

BIRTH NO. #79681 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 <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN <b>St. Louis, Mo.</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) <b>23- 2700 Indiana Ave</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>St. Louis City Hospital #1.</b>			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year) <b>Feb. 1st, 1950</b>		
a. (First) <b>LILLIAN</b>	b. (Middle) <b>GROH</b>	c. (Last)			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>9-6-1897</b>	9. AGE (In years last birthday) <b>52</b>	IF UNDER 1 YEAR Months   Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>

13a. FATHER'S NAME <b>Michael Reiter</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Charles Groh</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Charles Groh 2700 Indiana Ave</b>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Erysipema + multiple lung abscess</b>		DUPLICATE TO (b) <b>E. Poli + Clostridium welchii</b>				
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUPLICATE TO (c)				
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Hypertensive Cardiovascular Disease</b>						

19a. DATE OF OPERATION <b>1/17/50</b>		19b. MAJOR FINDINGS OF OPERATION <b>Rib resection + empyema drainage</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) <b>063X</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		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 12/20/49, 19, to 2/1/50, 19, that I last saw the deceased alive on 2/1/50, 19, and that death occurred at 6:00 PM from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>W. Turner, M.D.</b>		23b. ADDRESS <b>1515 Lafayette Ave.,</b>		23c. DATE SIGNED <b>2/2/50</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>2-4-1950</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Sunset Burial Park</b>	
DATE REC'D BY LOCAL REG. 1950 <b>FEB 2 1950</b>		REGISTRAR'S SIGNATURE <b>J. B. Lanter</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Ziegenbein Bros - 6409 Gravois Ave</b>	

(Licensed Embalmer's Statement on Reverse Side)

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

*Henry M. Brummer*

Licensed Embalmer No.

*4200*

P. O. Address

*St. Louis*

**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.