

FILED JUL 21 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24807**
Registrar's No. **5924**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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 St. Louis, Mo.		b. COUNTY St. Louis	
c. LENGTH OF STAY (In this place) 30 Min.		c. CITY (If outside corporate limits, write RURAL and give township) OR Riverview Gardens 4010	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Baptist Hospital		d. STREET ADDRESS (If rural, give location) 9758 Diamond Dr.	

3. NAME OF DECEASED (Type or Print)	a. (First) Wylie	b. (Middle) Dee	c. (Last) Grammer	4. DATE OF DEATH (Month) (Day) (Year) July 7 1950
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 7-22-1910	9. AGE (In years last birthday) 39
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Instrument Machinist		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Laneville, Texas	12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME Tribble Grammer	13b. MOTHER'S MAIDEN NAME Dora Skinner	14. NAME OF HUSBAND OR WIFE Pauline Grammer
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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) No	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Pauline Grammer	ADDRESS 9758 Diamond Dr.
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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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ ANTECEDENT CAUSES* Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Apoplexy 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 checked="" type="checkbox"/> NO <input 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)
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? 334X

22. I hereby certify that I attended the deceased from 19 10:30 p. to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 10:30 p. m., from the causes and on the date stated above.

23a. SIGNATURE <i>Calvin E. Feutz</i>	(Degree or title) 3	23b. ADDRESS 1300 Clark Ave	23c. DATE SIGNED 7-10-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7-11-1950	24c. NAME OF CEMETERY OR CREMATORY New Bethlehem	24d. LOCATION (City, town, or county) (State) St. Louis, County Mo.
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DATE REC'D BY LOCAL REG. JUL 10 1950	REGISTRAR'S SIGNATURE <i>J. B. Foster</i>	25. FUNERAL DIRECTOR'S SIGNATURE Calvin E. Feutz	ADDRESS Funeral Home
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

SEP 2

SEP 12 1950

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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 Ralph C. Linders

Licensed Embalmer No. 4275

P. O. Address H. Lantz, Wis.

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.