

FILED OCT 5 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31677

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7921

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
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 3213 Indiana		d. STREET ADDRESS (If rural, give location) 3213 Indiana	
3. NAME OF DECEASED (Type or Print) a. (First) Frank		b. (Middle) Gross	
c. (Last) Gross		4. DATE OF DEATH (Month) (Day) (Year) 9/18/50	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept. 21, 1873
9. AGE (In years last birthday) 76		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	11. BIRTHPLACE (State or foreign country) Austria
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Gross	
13b. MOTHER'S MAIDEN NAME Julia Fiedler		14. NAME OF HUSBAND OR WIFE Emma	
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 Emma Gross--3213 Indiana		ADDRESS	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <i>Cerebral Sclerosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs.</i> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Crisis of Liver Cirrhosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs.</i> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Anemia - det. Nephritis</i>	
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)			
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? <i>5810</i>			
22. I hereby certify that I attended the deceased from <i>9-1-</i> 1947, to <i>9-19-</i> 1950, that I last saw the deceased alive on _____, 19____, and that death occurred at <i>5:00a</i> m., from the causes and on the date stated above.			
23a. SIGNATURE <i>L. F. Murray M.D.</i>		23b. ADDRESS <i>625 - A - Russell</i>	
23c. DATE SIGNED <i>6-19-50</i>			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE <i>9/20/50</i>	
24c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran Cem.		24d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri	
DATE REC'D BY LOCAL REG. SEP 19 1950		REGISTRAR'S SIGNATURE <i>[Signature]</i>	
25. FUNERAL DIRECTOR'S SIGNATURE <i>Wacker-Weldale</i>		ADDRESS <i>3634 Gravois</i>	

(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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Robert Wheeler

Signed.....
Student Embalmer

Licensed Embalmer No..... *2128*

P. O. Address..... *St Louis Mo*

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.