

FILED APR 20 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3834
14152

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 Illinois b. COUNTY Greene	
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 White Hall 8120	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Baptist Hospital		d. STREET ADDRESS (If rural, give location) 8	

3. NAME OF DECEASED (Type or Print) Lillie Grunz			4. DATE OF DEATH (Month) (Day) (Year) April 9, 1951		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 26, 1886	9. AGE (In years last birthday) 65	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Scott Co., Ill.	
12. CITIZEN OF WHAT COUNTRY? U.S.					

13a. FATHER'S NAME Thomas McLamarrah		13b. MOTHER'S MAIDEN NAME Alice Cossey		14. NAME OF HUSBAND OR WIFE George F. Grunz	
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. Unknown		17. INFORMANT'S SIGNATURE OR NAME ADDRESS George F. Grunz, White Hall, Ill.	

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, asphyxia, 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) Chr. Myocarditis						1 yr +		
ANTECEDENT CAUSES			DUE TO (b) Coronary Hypertrophy			1 yr +		
			DUE TO (c) Hypertension			1 yr +		
II. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to the death but not related to the disease or condition causing death. Pleural Effusion						2 wks.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		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) 443X	
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? 11:30	

22. I hereby certify that I attended the deceased from **Mar 1, 1951**, to **Apr 9, 1951**, that I last saw the deceased alive on **4/8/51**, and that death occurred at **2:10 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE J. J. Ryan M.D. (Degree or title)		23b. ADDRESS 2602 S. Grand		23c. DATE SIGNED 4/9/51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 4-10-51		24c. NAME OF CEMETERY OR CREMATORY White Hall, Ill.	

DATE REC'D BY LOCAL REG. Apr 9		REGISTRAR'S SIGNATURE J. B. Lester		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd.	
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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

John Ambler

Licensed Embalmer No. _____

3653

P. O. Address _____

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.