

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10172

No. 300
10.48

FILED DEC 8 - 1951

318

1003

Registrar's No. 10172

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 10172	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis			
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (in this place) 6 hr		c. CITY (If outside corporate limits, write RURAL and give township) Baden Station		4010	
d. FULL NAME OF HOSPITAL OR INSTITUTION Alexian Brothers Hosp.				d. STREET ADDRESS (If rural, give location) R#3 Box 286			
3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) H. c. (Last) Grelle			4. DATE OF DEATH (Month) (Day) (Year) Nov 13th, 1951				
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH July 19th, 1879	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) gardner		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) St. Louis		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Joseph Grelle			13b. MOTHER'S MAIDEN NAME _____		14. NAME OF HUSBAND OR WIFE Elizabeth Grelle		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Agnes Grelle, R#3 Box 286, Baden Sta			
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) ACUTE INFARCT OF POSTERIOR WALL OF LEFT VENTRICAL WITH CONGESTIVE HEART FAILURE. DUE TO (b) CORONARY DISEASE OF HEART. DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 14 days	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" 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 4201			
22. I hereby certify that I attended the deceased from NOV 23, 1951 to NOV 12, 1951 , that I last saw the deceased alive on NOV 12, 1951 , and that death occurred at 1. ADAM , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Lothar Corneil M.D.				23b. ADDRESS 5005 A GRAVOIS ST. LOUIS 16 MO		23c. DATE SIGNED 11-14-51	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 11/16/51		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG. NOV 15 1951		REGISTRAR'S SIGNATURE Paul Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Diedrich F. Home		ADDRESS 8319 Hallsferry	

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

STATEMENT BY LICENSED EMBALMER

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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

Eleanora Bonice

Licensed Embalmer, No.

3403

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.