

No. 300
10.48

FILED AUG 29 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25754

State File No.

BIRTH NO. _____ REG. DIST. NO. 116 PRIMARY REG. DIST. NO. 3020 Registrar's No. 146

1. PLACE OF DEATH a. COUNTY Franklin		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Franklin	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Washington		c. CITY OR TOWN Lonedell, Mo.	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (in this place) 1 wk		STREET ADDRESS (If rural, give location) Highway 30, Prairie Twp.	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Francis Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Sadie b. (Middle) Belle c. (Last) Groh			4. DATE OF DEATH (Month) (Day) (Year) Aug. 19, 1955		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	
8. DATE OF BIRTH Nov. 2, 1880		9. AGE (In years last birthday) 74		IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 12 HRS: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.	
12. CITIZENSHIP OF WHAT COUNTRY? USA					

13a. FATHER'S NAME Frank R. Fisher		13b. MOTHER'S MAIDEN NAME Sadie Lenz		14. NAME OF HUSBAND OR WIFE John Groh	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Gladys Scharnhorst ADDRESS Lonedell, Mo.	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*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>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Heart Disease STATEMENT BY LICENSED EMBALMER ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause, last seen no behavior of any body which had last been observed by certified person DUE TO (b) Chol. Decomposition DUE TO (c) Obesity Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 48 h ? ?	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 4341					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input 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)		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 8-19, 1955, to 8-20, 1955, that I last saw the deceased alive on 8-19, 1955, and that death occurred at 1 A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) John A. Pearl M.D.		23b. ADDRESS St. Clair, Mo.		23c. DATE SIGNED 8-20-55	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Aug. 22-55		24c. NAME OF CEMETERY OR CREMATORY Laurel Hill	
				24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	

DATE REC'D BY LOCAL REG. 8/21/55		REGISTRAR'S SIGNATURE F. L. Heikmann		25. FUNERAL DIRECTOR'S SIGNATURE Chas. J. Lenot ADDRESS St. Clair, Mo.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

(Licensed Embalmer's Statement on Reverse Side)

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.....
Signature of Student Embalmer

Signed

H. M. Lend

Licensed Embalmer No. *365*

P. O. Address *St. Clair*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.