

FILED SEP 6 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27736

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **7218**

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 town or township) St. Louis	c. LENGTH OF STAY (In this place)	c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION De Paul Hospital		e. STREET ADDRESS (If rural, give location) 5331 Cote Brillante Ave.	

3. NAME OF DECEASED (Type or Print) a. (First) Mary	b. (Middle)	c. (Last) Greischar	4. DATE OF DEATH (Month) (Day) (Year) Aug. 18, 1955
--	-------------	-------------------------------	---

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Oct. 19, 1898	9. AGE (In years last birthday) (Months) (Days) (Hours) (Min.) 56
-------------------------	----------------------------------	--	--	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Kansas	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	-----------------------------------	---	---

13a. FATHER'S NAME Joseph Zollinger	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Victor Greischar
---	---	--

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 Jack J. Greischar	ADDRESS 5331 Cote Brillante
---	-------------------------	---	---------------------------------------

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, ashenia, 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) Arterial Hypertension.		
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Proximal Atherosclerosis			

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?
---	--	----------------------------

22. I hereby certify that I attended the deceased from **August 11, 1955**, to **August 18, 1955**, that I last saw the deceased alive on **August 18, 1955**, and that death occurred at **5 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Thomas J. Summers, M.D.	23b. ADDRESS 3903 Olive St. Louis, Mo.	23c. DATE SIGNED 8-18-55
--	--	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Aug. 19, 1955	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Kansas City, Mo.
---	-----------------------------------	------------------------------------	--

DATE REC'D BY LOCAL REG. AUG 18 1955	REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Chas. F. Stuart	ADDRESS 1225 Union Blvd.
--	---	--	------------------------------------

S.P. (Licensed Embalmer's Statement on Reverse Side)

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

SL

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 *Melvin L. Kesney*

Licensed Embalmer No. *405*

P. O. Address *3505 Q
St. Louis 20, Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.