

FILED SEP 1 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 27737  
Registrar's No. 6671

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE <u>Missouri,</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>	c. LENGTH OF STAY (in this place) <u>5 yrs</u>	c. CITY OR TOWN <u>St. Louis</u>	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: <u>City Hospital</u>		e. STREET ADDRESS (If rural, give location) <u>5083 Waterman Avenue</u> <u>8 2129</u>	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) <u>Rose</u>	b. (Middle) ---	c. (Last) <u>Grob</u>	(Month) <u>Aug.</u>	(Day) <u>1</u>	(Year) <u>1955</u>

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 23, 1867</u>	9. AGE (In years last birthday) <u>88 yrs</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 5 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Pocohontas, Illinois</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Solomon Weiss</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown Landolt</u>	14. NAME OF HUSBAND OR WIFE <u>Fred Grob</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Kate Kretschmar, 5083 Waterman Ave. 8</u>	ADDRESS
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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		INTERVAL BETWEEN ONSET AND DEATH <u>10 1/2</u>
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arterio Sclerosis</u>	ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u>		
	DUE TO (b) <u>Semility</u>		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>			

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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from July 25, 1955, to Aug 1, 1955, that I last saw the deceased alive on July 30, 1955, and that death occurred at 5 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Edw. Wilinski M.D.</u>	23b. ADDRESS <u>5402<sup>nd</sup> Groves Ave</u>	23c. DATE SIGNED <u>Aug 2, 1955</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>Aug. 4, 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Hug Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Millersburg, Illinois.</u>
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DATE REC'D BY LOCAL REG. <u>AUG 2 1955</u>	REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>CALVIN F. FEUER</u>	ADDRESS <u>4828 Natural Bridge Blvd. 15</u>
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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.....  
Signature of Student Embalmer

Signed *John A. Mena*.....

Licensed Embalmer No...*418*.....

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

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.