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FILED AUG 29 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 28487

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 590 Registrar's No. 1848

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rock Hill</b>		c. CITY OR TOWN <b>Glendale</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>4 Days</b>		STREET ADDRESS (If rural, give location) <b>15 Winnetka Ave.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Rock Hill Rest Home</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>EMILIE</b> b. (Middle) <b>M</b> c. (Last) <b>GROSS</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>8-6-1955</b>
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5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never married</b>	8. DATE OF BIRTH <b>2-11-1876</b>	9. AGE (In years last birthday) <b>79</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Artist</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Commercial</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Austria</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>William Gross</b>	13b. MOTHER'S MAIDEN NAME <b>Ernestine Bishop</b>	14. NAME OF HUSBAND OR WIFE <b>None</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. A.C. Hines</b> ADDRESS <b>405 N Sappington Rd.</b>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>18 days</b> <b>10 years</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Thrombosis</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Atherosclerosis</b> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>332X</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 7/19, 1955, to 8/6, 1955, that I last saw the deceased alive on 8/6, 1955, and that death occurred at 5:45 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Earl Brand MD</b>	23b. ADDRESS <b>Webster Groves 19 Mo</b>	23c. DATE SIGNED <b>8/8/55</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>8-9-1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis Mo.</b>
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DATE REC'D BY LOCAL REG. <b>8/8/55</b>	REGISTRAR'S SIGNATURE <b>Herbert R. Donker MD</b>	FUNERAL DIRECTOR'S SIGNATURE <b>Walter Aldrich</b> ADDRESS <b>7 Home Webster Groves Mo.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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 *Neville B. Frohwitter*

Licensed Embalmer No. *369*

P. O. Address *15 W. Locust*

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.