

FILED SEP 13 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

28543

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 017 PRIMARY REG. DIST. NO. 500 Registrar's No. 2002

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Lemay</u>	c. LENGTH OF STAY (in this place) <u>2 yrs.</u>	c. CITY OR TOWN <u>Lemay, Mo.</u>	d. In Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>229 Horn ave</u>		e. STREET ADDRESS (If rural, give location) <u>229 Horn ave.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Gussie</u> b. (Middle) <u>M.</u> c. (Last) <u>Grate</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 26, 1955</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>January 18, 1882</u>	9. AGE (In years) (at birthday) <u>73</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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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>At Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Louisiana, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13a. FATHER'S NAME <u>Unknown Frier</u>	13b. MOTHER'S MAIDEN NAME <u>Anna Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Fred</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>Walter Grate</u>	ADDRESS <u>229 Horn ave. Lemay, Mo.</u>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerosis of the Arteries</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis General</u> DUE TO (c) <u>Hypertension</u>		
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 _____	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) <u>none</u> m.	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 11/15, 1952 to 8-26, 1955, that I last saw the deceased alive on 8/2, 1955, and that death occurred at 6:30 a m., from the causes and on the date stated above.

23a. SIGNATURE <u>Robert G. Warner M.D.</u> (Degree or title)	23b. ADDRESS <u>1115 Paul Brown Bldg. No 8/26/55</u>	23c. DATE SIGNED _____
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24a. BURIAL, CREMATION REMOVAL (Specify) <u>Cremation</u>	24b. DATE <u>Aug. 29, 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Crematory</u>	24d. LOCATION (City, town, or county) (State) <u>7600 St. Charles Road Mo.</u>
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DATE REC'D BY LOCAL REG. <u>8/27/55</u>	REGISTRAR'S SIGNATURE <u>Robert R. Dombke M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>C. Hoffmeister</u>	ADDRESS <u>U. &amp; L. Co. 7814 S. Broadway</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.....  
Licensed Embalmer No. 2679

P. O. Address 7814 3rd Ave

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.