

FILED SEP 29 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30903

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8109**

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO. b. COUNTY _____	
b. CITY OR TOWN ST. LOUIS	c. LENGTH OF STAY (In this place) _____	c. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS	d. STREET ADDRESS (If rural, give location) 3063^a MARCUS
d. FULL NAME OF HOSPITAL OR INSTITUTION DR. J. H. HOPKINS		d. STREET ADDRESS (If rural, give location) 3063^a MARCUS	

3. NAME OF DECEASED (Type or Print) a. (First) JOHN b. (Middle) JOSEPH c. (Last) GRICUS			4. DATE OF DEATH (Month) (Day) (Year) SEPT. 15, 1955		
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH JUNE 24, 1880	9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Months _____	IF UNDER 10 HRS. Hours _____	IF UNDER 15 MIN. Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR	10b. KIND OF BUSINESS OR INDUSTRY GENERAL	11. BIRTHPLACE (State or foreign country) LITHUANIA	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME UNKNOWN	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE NONE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 489-16-6358	17. INFORMANT'S SIGNATURE OR NAME Mrs. Veronica Johnson	ADDRESS 3063^a MARCUS
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis DUE TO (c) Heart Disease		INTERVAL BETWEEN ONSET AND DEATH
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 420.0	20. AUTOPSY? YES <input checked="" 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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, _____, _____, from the causes and on the date stated above.

23a. SIGNATURE Joseph M. DePaulis	23b. ADDRESS 300^a Olive	23c. DATE SIGNED 9/15/55
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24a. BURIAL (CREMATION REMOVAL) (Specify) _____	24b. DATE Sept 17, 1955	24c. NAME OF CEMETERY OR CREMATORY CALVARY	24d. LOCATION (City, town, or county) (State) ST. LOUIS MO.
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DATE REC'D BY LOCAL REG. SEP 15 1955	REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE John J. Kasely	ADDRESS St. Louis Mo
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(Licensed Embalmer's Statement on Reverse Side)

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

2091A

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body *Embalmed* whose name is recorded on the reverse side of this certificate was embalmed by me, or by

Student Embalmer No. *77*

working under my personal supervision.

Student *Not* Student Embalmer

Signed *John J. Kewly*

Licensed Embalmer No. *6855*

P. O. Address *E. St Louis Ill*

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