

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35574**
Registrar's No. **9368**

FILED NOV 16 1956

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 Missouri b. COUNTY	
b. CITY OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Gietner Home		e. STREET ADDRESS (If rural, give location) 2157 D 5000 S. Broadway	

3. NAME OF DECEASED (Type or Print) EMMA GROSSWILER			4. DATE OF DEATH (Month) (Day) (Year) Oct 13 1956		
a. (First)		b. (Middle)		c. (Last)	

5. SEX female		6. COLOR OR RACE white		7. MARRIED-NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed		8. DATE OF BIRTH Dec 20, 1868		9. AGE (In years last birthday) 87		IF UNDER 1 YEAR Months Days		IF UNDER 10 HRS. Hours Min.	
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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) St. Charles, Missouri			12. CITIZEN OF WHAT COUNTRY? USA		
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13a. FATHER'S NAME Frederick Lienemann			13b. MOTHER'S MAIDEN NAME Elizabeth Bleffe			14. NAME OF HUSBAND OR WIFE Nickolas (deceased)		
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Charles Murray 6200 Sunshine			
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arterio sclerotic Heart Disease		DUPLICATE OF (b) General Arterio sclerosis						years	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUPLICATE OF (c)						years	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cerebro-malacia Fractured R. hip + operation								months 2 mo. approx.	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 420.0 F						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 **10/17**, 19**52**, to **10/13**, 19**56**, that I last saw the deceased alive on **10/13**, 19**56**, and that death occurred at **10:15 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE J. J. Moskopf, M.D. (Degree and Title)		23b. ADDRESS 3554 VICTOR ST. STL 4 Mo.		23c. DATE SIGNED 10/14/56	
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24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 10/16/56		24c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		24d. LOCATION (City, town, or county) (State) St. Charles, Mo.	
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DATE REC'D BY LOCAL REG. OCT 15 1956		REGISTRAR'S SIGNATURE Earl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J L Ziegenhein & Sons 7027 Gravois	
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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.....

P. O. Address.....

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.