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SL-1225 FILED JAN 15 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43110
STATE FILE NUMBER 11625

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ILLINOIS b. COUNTY ST. CLAIR | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N. Grand, St. Louis, Mo. | | c. CITY OR TOWN EAST ST. LOUIS 8120 8 | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Vet. Adm. Hospital | | d. STREET ADDRESS 1417 ST. LOUIS AVE | |
| Length of stay in lb 4 days | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |

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|---|---------------------------|---|--|--|---|------------------|
| 3. NAME OF DECEASED (Type or print) First MIDDLE Last JOSEPH M. GRENIUS | | | 4. DATE OF DEATH Month Day Year 12-18-56 | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3-13-87 | 9. AGE (In years last birthday) 69 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ODD JOBS | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) LITHUANIA | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME MARTIN GRENIUS | | | 14. MOTHER'S MAIDEN NAME MAY AUGUST | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-I | | 16. SOCIAL SECURITY NO. UNKNOWN | | 17. INFORMANT Address VA Hosp. Records, 915 N. Grand, St. Louis, Mo. | | |

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|---|--|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PULMONARY EMBOLISM | | | | UNK | |
| DUE TO (b) ACUTE MYOCARDIAL INFARCTION | | | | UNK | |
| DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE - 420.0 | | | | UNK | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ACUTE CEREBRAL INFARCTION - - - - | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |

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|---|--|--|--|---|--|
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> NONE | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | |
| 20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m. | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |

21. I attended the deceased from 12-14-56 to 12-18-56 and last saw ~~me~~ him alive on 12-18-56
Death occurred at 9:05 A m on the date stated above; and to the best of my knowledge, from the causes stated.

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|---|--|------------------------------|
| 22a. SIGNATURE (Name or title) <i>J. J. Kassly</i> | 22b. ADDRESS 915 N. Grand Blvd. M.D. VA Hosp. St. Louis, Mo. | 22c. DATE SIGNED 12-18-56 |
|---|--|------------------------------|

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|--|-----------------------------------|--|---|
| 23a. BURIAL, CREMATION, OR REMOVAL (Specify) | 23b. DATE 12-19-56 | 23c. NAME OF CEMETERY OR CREMATORY S. M. D. | 23d. LOCATION (City, town, or county) (State) Belleville, Illinois |
| 24. FUNERAL DIRECTOR J. J. Kassly | ADDRESS E. St. Louis, Illinois | 25. DATE RECD. BY LOCAL REG. DEC 19 1956 | 26. REGISTRAR'S SIGNATURE <i>Carl Smith</i> |

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.. *Not Embalmed*

Student.....
Signature of Student Embalmer

Signed..... *John G. Kasaly*.....
Licensed Embalmer No.....

P. O. Address.....

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**.
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.