

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **10343**
2012

FILED MAR 18 1957

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

Health, Welfare Public Service
300 1-56
All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN ST. LOUIS			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL			Length of stay in 1b 70 Years		d. STREET ADDRESS (If outside, give location) 4264 SHENANDOAH STREET		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ROSE Middle A. Last GRUENE				4. DATE OF DEATH Month FEB. Day 26, Year 1957			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEBRUARY 14, 1887		9. AGE (In years last birthday) 70 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) CASHIER (Retired)			10b. KIND OF BUSINESS OR INDUSTRY PAPER MFG.	11. BIRTHPLACE (City and state or country) ST. LOUIS, MISSOURI		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME FRED GRUENE				14. MOTHER'S MAIDEN NAME WILHELMINA KLUEGEL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 488-01-6166		17. INFORMANT Address MISS IDA GRUENE 4264 SHENANDOAH STREET			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Chronic Bronchitis and Asthma DUE TO (c) 490x PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH 36 HRS. 14 Yrs.	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			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 FEB 1946 to FEB. 26, 1957 and last saw her/him alive on FEB. 26, 1957 Death occurred at 4:25 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>C. P. Vermillion, M.D.</i> M.D.				22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 2/27/1957	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 3-1-57	23c. NAME OF CEMETERY OR CREMATORY NEW BETHLEHEM CEMETERY		23d. LOCATION (City, town, or county) (State) ST. LOUIS COUNTY, MISSOURI		
24. FUNERAL DIRECTOR ADDRESS HEIDERWIEDEN F.H. INC. 1936 ST. LOUIS AV.				25. DATE RECD. BY LOCAL REG. FEB 28 '57		26. REGISTRAR'S SIGNATURE <i>Carl Smith MD</i> mjs	

ST. LOUIS, MO.

FEB. 20 1927

EMBALMER

.A

NO. 1

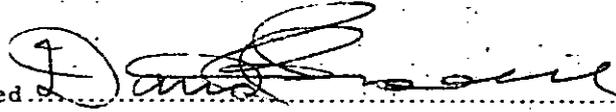
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by _____, Student Embalmer No. _____

working under my personal supervision..

Student _____
Signature of Student Embalmer

Signed  _____

Licensed Embalmer No. 45

P. O. Address St. Louis

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