

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38721

STATE FILE NUMBER

FILED OCT 16 1957

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2293

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>ST. LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>GARDENVILLE</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>GARDENVILLE 4810</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>7648 FLETA</u>		Length of stay in 1b <u>12 YRS.</u>	d. STREET ADDRESS (If outside, give location) <u>7648 FLETA</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES S GROUT</u>			4. DATE OF DEATH Month Day Year <u>SEPT 14 1957</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 31, 1886</u>
9. AGE (In years last birthday) <u>70</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATCHMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DEPT. STORE</u>	11. BIRTHPLACE (City and state or country) <u>CHELSEA, MASS.</u>
13. FATHER'S NAME <u>NOT KNOWN</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
14. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>		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>493-05-4065</u>		17. INFORMANT Address <u>MRS DOTTIE PRIMM 7648 FLETA</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>ARTERIO SCLEROSIS</u> DUE TO (c) <u>ARTERIAL HYPERTENSION 381X</u> 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 <u>2</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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 <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 <u>9-14-57</u> to <u>9-14-57</u> and last saw her/him alive on <u>9-14-57</u> Death occurred at <u>6:15p</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Eugene H. Dittmattler D. O.</u>		22b. ADDRESS <u>8604 GRAVOIS AVE</u>	
22c. DATE SIGNED <u>9-16-57</u>		23a. BURIAL, CREATION, REMOVAL (Specify) <u>BURIAL</u>	
23b. DATE <u>9-17-57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVE CEMETERY</u>	
23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS CO., MO.</u>		24. FUNERAL DIRECTOR ADDRESS <u>J L ZIEGENHEIN &amp; SONS 7027 GRAVOIS</u>	
25. DATE RECD. BY LOCAL REG. <u>9/17/57</u>		26. REGISTRAR'S SIGNATURE <u>Herbert B. Domb</u>	

(Licensed Embalmer's Statement on Reverse Side)

Health & Welfare  
Public Health Service  
S. 300  
1-56  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. 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.  
Securing the medical certification in the specific manner required by 193.140 MoRS 1939.

1000-20-200

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 *Ronald E. Benz* \_\_\_\_\_

Licensed Embalmer No. *4863*

P. O. Address *7027 Iowa*

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.