

FILED DEC 2 - 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

1003

42027  
STATE FILE NUMBER  
11177  
Registrar's No.

Registration District No. 318 Primary Registration District No.

S. 300  
ev. 1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS MO.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>25 ST. LOUIS CITY HOSP.</b>		Length of stay in lb. <b>78 Yrs formerly</b>	d. STREET ADDRESS (If outside, give location) <b>4318 N. 20th St</b> Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>GOTTLIEB</b> Middle <b>GRIESMANN</b> Last			4. DATE OF DEATH Month <b>NOV.</b> Day <b>16,</b> Year <b>1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 7, 1879</b>
9. AGE (in years last birthday) <b>78</b>	10. UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Blacksmith</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wagon Mfg.</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>(Unknown) Griesmann</b>	
13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Katherine Griesmann</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs Olga Mitchler, 4977 Pernod</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gangrene of bowel</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO: (b) <b>Strangulated inguinal hernia</b> DUE TO: (c) _____ 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
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		561.0	
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 <b>11/13/57</b> to <b>11/16/57</b> and last saw <sup>her</sup> him alive on <b>11/16/57</b> Death occurred at <b>9:35 PM</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Joseph J. Kalbac M.D.</b>		22b. ADDRESS <b>1515 LAFAYETTE AVE.</b>	
22c. DATE SIGNED <b>11/16/57</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Nov. 22, 1957</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>New Bethlehem Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>	
24. FUNERAL DIRECTOR <b>BEIDERWIEDEN F.H. INC. 1936 St. Louis Ave</b>		25. DATE RECD. BY LOCAL REG. <b>NOV 29 57</b>	
26. REGISTRAR'S SIGNATURE <b>Carl Smith MD</b> mbs			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Securing the medical certification in the specific manner required by 193.140 MoRS 1742.

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 *Delis J. Krupin* \_\_\_\_\_

RECEIVED  
RECEIVED  
RECEIVED  
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.