

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-007284
STATE FILE NUMBER
1547

FILED FEB 28 1958

Registration District No. 318 Primary Registration District No. 1003

Registrar's No.

300
1-57

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>Franklin</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Gray Summit</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>Mo. Baptist</u>		Length of stay in 1b <u>4 da.</u>	d. STREET ADDRESS (If outside, give location) <u>3/</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ursula Ella Groff</u>			4. DATE OF DEATH Month Day Year <u>Feb 8 1958</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 13, 1880</u>
9. AGE (In years last birthday) <u>77</u>		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) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTH PLACE (City and state or country) <u>Gray Summit, Mo</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13a. FATHER'S NAME <u>Andrew Morgan Groff</u>	
13b. MOTHER'S MAIDEN NAME <u>Rebecca Coleman</u>		14. NAME OF HUSBAND OR WIFE <u>Spencer Groff (bro) Gray Summit Mo.</u>	
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. <u>none</u>	17. INFORMANT <u>Spencer Groff (bro) Gray Summit Mo.</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>pulmonary infarction</u> <u>fracture rt hip joint</u> DUE TO (b) <u>fractured rt hip joint</u> DUE TO (c) <u>E902.0</u> CONDITIONS (If any, which gave rise to terminal disease (a), (b), (c), or (d), and the underlying cause last.) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>2/</u>			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input checked="" 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.) <u>slipped while getting out of bed; out of bed</u> <u>fractured rt hip joint and complication</u>		20c. TIME OF INJURY Hour Month, Day, Year <u>2:30 PM 2/8/58</u>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (S.G., in or about home, farm, factory, street, office bldg., etc.) <u>31 Home in Bed Room</u>	
20f. CITY, TOWN, OR LOCATION <u>036</u>		COUNTY STATE	
21. I attended the deceased from <u>Jan 19 1935</u> to <u>Feb 19 1958</u> and last saw her <u>alive on 8th Feb 1958</u> . Death occurred at <u>2:30 AM 7:30 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>W.B. Ecker MD</u>		22b. ADDRESS <u>Pacific Mo.</u>	
22c. DATE SIGNED <u>2/10/58</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Feb 11 1958</u>		23b. DATE	
23c. NAME OF CEMETERY OR CREMATORY <u>Brush Creek Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Gray Summit Mo.</u>	
24. FUNERAL DIRECTOR <u>Mrs. John L. Thebes Pacific Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>FEB 10 1958</u>	
26. REGISTRAR'S SIGNATURE <u>Charles Smith MD</u>			

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.

8001 18 4NF

JAN 28 1963

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 *E. F. Olstmann*

Licensed Embalmer No. *1686*
P. O. Address *Union, Mo.*

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.