

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-016845  
STATE FILE NUMBER

FILED MAY 12 1958

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 1165

300  
1-57  
004

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Berkeley</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Jennings</b> <b>4138<sup>0</sup></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>Penn Nursing Home</b>		Length of stay in 1b <b>16 months</b>	d. STREET ADDRESS (If outside, give location) <b>8624 Clifton Ave.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>MATHILDA GRAM</b>			4. DATE OF DEATH Month <b>Apr.</b> Day <b>26</b> Year <b>1958</b>		
First	Middle	Last	Month	Day	Year

5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 20, 1874</b>	9. AGE (In years last birthday) <b>83</b>	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) <b>housework</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
---	--	--	---

13a. FATHER'S NAME <b>Tobias Bischof</b>	13b. MOTHER'S MAIDEN NAME <b>Theresa Rutzel</b>	14. NAME OF HUSBAND OR WIFE <b>Frank J. Gram</b>
---	--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Charles E. Bischof</b>	Address <b>1537 Veronica Ave.</b>
--	--	--	--------------------------------------

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>Hypertensive Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>
--	--	--

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) \_\_\_\_\_

DUE TO (c) \_\_\_\_\_

**443X**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)  
**Arteriosclerotic Dementia**

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 _____ a.m. _____ p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20e. CITY, TOWN, OR LOCATION	COUNTY	STATE
---	--	------------------------------	--------	-------

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 Death occurred at <b>Dec 14, 1956</b> to <b>April 26, 1958</b> and last saw her alive on <b>4/22/58</b> at <b>2:15 PM</b> on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <b>Lewis Littmann MD</b> (Doctor or title)	22b. ADDRESS <b>8231 Clayton Rd (17)</b>	22c. DATE SIGNED <b>4/28/58</b>
--	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>4/29/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) <b>St. Louis Mo.</b>	(State)
---	-----------------------------	---	---	---------

24. FUNERAL DIRECTOR <b>Puchholz Mortuary</b>	ADDRESS <b>5967 W. Florissant</b>	25. DATE RECD. BY LOCAL REG. <b>4-28-58</b>	26. REGISTRAR'S SIGNATURE <b>Herbert B. Donahoe MD</b>
--	--------------------------------------	--	---

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.

87.

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 *Walter A. Burckhoff*

Licensed Embalmer No. *4551*  
P. O. Address *St. Louis*

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.