

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-027005

STATE FILE NUMBER

FILED AUG 6 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

7321

| | | | | | |
|--|------------------------------|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>St. Louis</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis City Hosp. #1</u> | | Length of stay in 1b <u>#1</u> | d. STREET ADDRESS (If outside, give location) <u>2109 3540 N. Grand</u> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>Michael</u> Middle <u>Joe</u> Last <u>Groniek</u> | | | 4. DATE OF DEATH Month <u>July</u> Day <u>24</u> Year <u>1958</u> | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</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>1-4-1898</u> | | 9. AGE (In years last birthday) <u>60</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grinder</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Wagner Elec Co</u> | | 11. BIRTHPLACE (City and state or country) <u>St. Louis Mo.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> |
| 13a. FATHER'S NAME <u>Michael Groniek</u> | | 13b. MOTHER'S MAIDEN NAME <u>Unknown</u> | | 14. NAME OF HUSBAND OR WIFE <u>Ida Groniek</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, of what service) <u>Yes</u> | | 16. SOCIAL SECURITY NO. <u>494-10-7907</u> | | 17. INFORMANT Address <u>Ida Groniek, 3540 N. Grand</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>transitional cell carcinoma of the urinary bladder</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>unk.</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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). <u>Far advanced pulmonary tuberculosis.</u> | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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. 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 <u>July 1, 1958</u> to <u>July 24, 1958</u> and last saw her/him alive on <u>July 24, 1958</u> Death occurred at <u>10:57</u> p. m. on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE <u>Jean O. Chapman, M.D.</u> (Degree or title) | | | 22b. ADDRESS <u>1515 Lafayette Ave.</u> | | 22c. DATE SIGNED <u>7/25/58</u> |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 22b. DATE <u>7-28-58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park CEM.</u> | | 22d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo</u> |
| 24. FUNERAL DIRECTOR <u>Edw Koel + son</u> ADDRESS <u>-3526 E 14</u> | | 25. DATE RECD. BY LOCAL REG. <u>JUL 26 1958</u> | | 26. REGISTRAR'S SIGNATURE <u>J. Earl Smith, M.D.</u> S.P. | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

OCT 17 1961

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

Gustav W. Seiter

Licensed Embalmer No. 4329

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.