Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003003

STATE FILE NUMBER 2 640

FILED FEB 3 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS — Inside Limits Yes ☐ No ☐	c. CITY OR TOWN ST. LOUIS — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) MISSOURI BAPITST HOSP. — Length of stay in 1b	d. STREET ADDRESS 4040 (If outside, give location) LOUIS — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
CYNTHIA	MARY	GROTE	JAN	17	1959

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
FEMALE	WHITE		OCT 7, 1955	3				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY?
-----	-----	ST. LOUIS, MO.	USA

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
ROBERT T GROTE	DOROTHY MAJEWSKI	-----

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	Address
NO		NONE	ROBERT T GROTE	4040 LOUIS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) lobar pneumonia

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 7 4 hr.

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

DUE TO (b) _____

DUE TO (c) 490X

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

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 1/8/59 to 1/16/59 and last saw her/him alive on 1/16/59

Death occurred at 6:30 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Jos. Trigg (Degree or title) M.D.

22b. ADDRESS 7165 Delmar

22c. DATE SIGNED 1/19/59

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
BURIAL	1/20/1959	CALVARY CEMETERY	ST. LOUIS, MO.

24. FUNERAL DIRECTOR	ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
J L ZIEGENHEIN & SONS	7027 GRAVOIS	JAN 19 '59	Earl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 .....

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.