Health, Welfare Public Service

300 -57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003714
STATE FILE NUMBER

JAN 19 1959 Registration District No. 317 Primary Registration District No. 634 Registrar's No. 49

1. PLACE OF DEATH a. COUNTY ST. LOUIS	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ILLINOIS b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CLAYTON — Inside Limits Yes ☒ No ☐	c. CITY OR TOWN GRANITE CITY 2120 — Inside Limits Yes ☐ No ☒
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION COUNTY HOSPITAL — Length of stay in Ib DOA	d. STREET ADDRESS (If outside, give location) 3085 WAYNE — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
EMMA	E	GROBELNIK	JAN	3	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		APRIL 7, 1923	35				

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?
HOUSEWIFE	AT HOME	ILLINOIS	USA

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
CHARLES LIZENBY	EUNICE NOON	JOSEPH

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		311-20-3894	JOSEPH GROBELNIK	3085 WAYNE

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Coronary Occlusion

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) 4201

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 _____, to _____ and last saw her/him alive on _____

Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)	22b. ADDRESS	22c. DATE SIGNED
John C. Murphy MD Acting Health Commissioner	801 S. Brentwood Clayton, Mo.	1/9/59

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
BURIAL	1/6/1959	MT. HOPE CEMETERY	ST. LOUIS CO., MO.

24. FUNERAL DIRECTOR	ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
J L ZIEGENHEIN & SONS	7027 GRAVOIS	1-6-59	Herbert L. Klonke, M.D.

(Licensed Embalmer's Statement on Reverse Side)

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.