

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-004697  
STATE FILE NUMBER

FILED MAR 16 1959

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 72

300  
-57 2

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Callaway</u>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Gasconade</u>                |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Fulton</u>   |                                  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN <u>Swiss</u> <u>0370</u><br>Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>             |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>St. Hospital No. 1</u>   |                                  | Length of stay in lb <u>12 yrs.</u>   | d. STREET ADDRESS ----- (If outside, give location)<br>Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print) First <u>Henry</u> Middle _____ Last <u>Gruber</u>  |                                  |   | 4. DATE OF DEATH<br>Month <u>March</u> Day <u>13</u> Year <u>1959</u>   |
| 5. SEX<br><u>Male</u> c  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>May 12, 1887</u>   |
| 9. AGE (In years (birthdays))<br><u>72</u>   |                                  | IF UNDER 1 YEAR<br>Months _____ Days _____  | IF UNDER 24 HRS.<br>Hours _____ Min. _____  |
| 10a. USUAL OCCUPATION (Give kind of work done during term of life, even if retired)<br><u>Farm hand</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Same</u>  | 11. BIRTHPLACE (City and state or country)<br><u>Swiss, Missouri</u> c  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |                                  | 13a. FATHER'S NAME<br><u>Henry Gruber</u>   |   |
| 13b. MOTHER'S MAIDEN NAME<br><u>Elizabeth Fluestch</u>   |                                  | 14. NAME OF HUSBAND OR WIFE<br><u>None</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or UNKOWN. Give war or dates of service)<br><u>Unknown</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>Unknown</u>   | 17. INFORMANT<br><u>State Hospital No. 1, Fulton, Missouri</u><br>Address _____   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>  |                                  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____   |                                  |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>Borderline Intelligence with psychosis</u> <u>4201</u>           |                                  |   | 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____ Month, Day, Year _____<br>a.m. _____ p.m. _____  |                                  |   |   |
| 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. Attended the deceased from _____ to _____ and last saw him <u>xxxxxxx</u><br>Death occurred at <u>1:10 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated. |                                  |   |   |
| 22a. SIGNATURE<br><u>Dean Reed</u> (Degree or title) _____   |                                  | 22b. ADDRESS<br><u>State Hospital No. 1</u>   | 22c. DATE SIGNED<br><u>3-13-59</u>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Cremation</u>  | 23b. DATE<br><u>Mar 15 59</u>    | 23c. NAME OF CEMETERY OR CREMATORY<br><u>St. Johns E.P. Cem</u>   | 23d. LOCATION (City, town, or county) (State)<br><u>Hermann A70 Mo</u>  |
| 24. FUNERAL DIRECTOR<br><u>Paul H. Sumner</u> <u>Berger Mo</u> ADDRESS _____   |                                  | 25. DATE RECD. BY LOCAL REG.<br><u>March 13-1959</u>  | 26. REGISTRAR'S SIGNATURE<br><u>Martha Lawrence</u>   |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MAR 19 1959

**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 *Hugo H. Blumer* .....

Licensed Embalmer No. *3160* .....

P. O. Address *Hermann W* .....

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.