

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007154
STATE FILE NUMBER
2 1692

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 Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION City Hospital		d. STREET ADDRESS 4472 Beck	
Length of stay in 1b		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Frieda Elizabeth Greb			4. DATE OF DEATH Month Day Year Feb 17 1959		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 15 1890	9. AGE (In years last birthday) 69	10. UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Manchester Mo 0	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Joseph Remphry	13b. MOTHER'S MAIDEN NAME Elizabeth Migneron	14. NAME OF HUSBAND OR WIFE Edwin Greb
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. 492 20 8887	17. INFORMANT Address Lillian Sanders 6843a Bradley
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bilateral Lobar Pneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Ingestion of Amanita</i> DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Self suggested in Home</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in PART I or PART II of item 18.) <i>Wife suffered from temporary mental aberration on</i>
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. 2 13 59	<i>February 13 1959</i>	E971.3
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, store, office, place, etc.) <i>Home</i>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <i>St. Louis Mo</i>
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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) <i>Robert C Taylor 3</i>	22b. ADDRESS <i>1300 Elm -</i>	22c. DATE SIGNED <i>2/17/59</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Feb 19 59	23c. NAME OF CEMETERY OR CREMATORY St. Paul Church	23d. LOCATION (City, town, or county) (State) DesPeres Mo
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24. FUNERAL DIRECTOR ADDRESS E. J. Schnur 3125 Lafayette	25. DATE RECD. BY LOCAL REG. FEB 17 '59	26. REGISTRAR'S SIGNATURE <i>Robert Smith, M.D.</i>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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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 *Thomas R. Smith*

Licensed Embalmer No. *3793*

P. O. Address *3125 Laurel*

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.