

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015107

STATE FILE NUMBER

FILED MAY 14 1959

Registration District No. _____ Primary Registration District No. _____

Registrar No. 4364

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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		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Luke's Hospital		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 6717 Neosho
3. NAME OF DECEASED (Type or print) First Middle Last Grover Cleveland Hess			4. DATE OF DEATH Month Day Year May 2, 1959
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 22, 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Automobile Salesman		10b. KIND OF BUSINESS OR INDUSTRY Patterson Ford	9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 65 Months Days Hours Min.
11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Harry Hess		13b. MOTHER'S MAIDEN NAME (unknown)	14. NAME OF HUSBAND OR WIFE Ruth Jane Hess (nee Babbitt)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes World War I		16. SOCIAL SECURITY NO. Yes	17. INFORMANT Mrs. Ruth Jane Hess, 6717 Neosho, St. Louis
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>Pneumonia - (Staphylococcal)</i>			INTERVAL BETWEEN ONSET AND DEATH <i>5 weeks</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Granuloma of colon - mucrotitis chronic</i>			
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year g.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>7/27/57</u> to <u>5/2/59</u> and last saw her alive on <u>5/2/59</u> Death occurred at <u>1:20 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Robert Panie M.D.</i>		22b. ADDRESS <i>3720 Washington St. San</i>	22c. DATE SIGNED <i>5/4/59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>5/5/1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Lebanon Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis County, Missouri</i>
24. FUNERAL DIRECTOR ADDRESS <i>Hoffmeister Colonial Mortuary</i>		25. DATE RECD. BY LOCAL REG. <i>MAY 4 '59</i>	26. REGISTRAR'S SIGNATURE <i>Roal Smith, M.D.</i>

6464 Chippewa Street, St. Louis (Licensed Embalmer's Statement on Reverse Side)

mjs

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Linus C. Hoffmeister*

Licensed Embalmer No. *3871*

P. O. Address *7814 S. Bruce*

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.