

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026704

FILED VS AUG 4 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2-6857** STATE FILE NUMBER

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		Length of stay in 1b 27 yrs	
c. FULL NAME OF (If NOT in hospital, give location), HOSPITAL OR INSTITUTION Lutheran Hospital		d. STREET ADDRESS (If outside, give location) 5233a Sutherland Ave	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) REV. GERHARD H. GROERICH			4. DATE OF DEATH Month July Day 21 Year 1959		
5. SEX male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/29/1892	9. AGE (last birthday) 66	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION: (Give kind of work done during most of working life, even if retired) Lutheran minister		10b. KIND OF BUSINESS OR INDUSTRY Lutheran church		11. BIRTHPLACE (City, and state or country) Nebraska	
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Rev. Albert D. Groerich		13b. MOTHER'S MAIDEN NAME Katherine Marting	
14. NAME OF HUSBAND OR WIFE Katherine Pries		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. 496-40-2582	
17. INFORMANT Mrs. Katherine Groerich, 5233a Sutherland		Address			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH minutes
IMMEDIATE CAUSE (a) Acute myocardial Infarction		
DUE TO (b) Hypertensive and Arteriosclerotic Heart Disease		
DUE TO (c) 4201		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic Cardiac Decomensation; Auricular Fibrillation		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 Hour _____ a.m. _____ p.m. Month, Day, Year _____	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 St. Louis, Missouri	20g. COUNTY	20h. STATE
21. I attended the deceased from 7/20/59 at 9AM , to 7/21/59 and last saw him/her alive on 7/20/59 . Death occurred at 10:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) Charles G. Obermayer M.D.		22b. ADDRESS 4401 Hampton		22c. DATE SIGNED 7/21/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE July 24, 1959		23c. NAME OF CEMETERY OR CREMATORY Western Lutheran Cemetery	
23d. LOCATION (City, town, or county) St. Louis, Missouri		24. FUNERAL DIRECTOR BEIDERWIEDEN F.H. INC., 1936 St. Louis Ave		25. DATE RECD. BY LOCAL REG. JUL 23 '59	
26. REGISTRAR'S SIGNATURE Earl Smith, M.D.					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

PL-3-3721

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Homer H. Jwitz

Licensed Embalmer No. 388

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.