

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027680

FILED VS AUG 10 1959

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2041

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Creve Coeur</b>		Length of stay in 1b <b>13 days</b>	c. CITY OR TOWN <b>Creve Coeur</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Green Valley Conv. Home</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>#3 Trojan Place</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Philip</b> Middle <b>George</b> Last <b>Grieb</b>			4. DATE OF DEATH Month <b>July</b> Day <b>29</b> Year <b>1959</b>			
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3-31-69</b>	9. AGE (last birthday) <b>90</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	11. BIRTHPLACE (City and state or country) <b>Creve Coeur, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Conrad Grieb</b>	13b. MOTHER'S MAIDEN NAME <b>Philippine Deuser</b>	14. NAME OF HUSBAND OR WIFE <b>- - - - -</b>
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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) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Dora C. Grieb, #3 Trojan Place</b>	Address
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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) <b>Cerebral Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 month over 3 yrs. post mortem</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Arteriosclerosis, generalized</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) <b>Arteriosclerotic Sanguine or feet</b>		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
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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.) _____
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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 _____	COUNTY _____	STATE _____
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21. I attended the deceased from <b>12/26/56</b> to <b>7/29/59</b> and last saw him alive on <b>7/21/59</b> Death occurred at <b>11:30 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) <b>Paul S. Hughes, M.D.</b>	22b. ADDRESS <b>11600 Olive St. Rd.</b>	22c. DATE SIGNED <b>7/31/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>8-1-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Ev. Cemetery Olivette, Missouri</b>	23d. LOCATION (City, town, or county) (State) <b>Missouri</b>
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24. FUNERAL DIRECTOR <b>Baumann Bros. Inc. Overland, Mo.</b>	ADDRESS <b>2504 Woodson Rd.</b>	25. DATE RECD. BY LOCAL REG. <b>7-31-59</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 David C. Geb

Licensed Embalmer No. 345

P. O. Address Overland

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.