

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030441

FILED VS AUG 27 1959

2. 7506

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. \_\_\_\_\_

DED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Missouri</b>		c. CITY OR TOWN <b>St. Louis,</b>	
Length of stay in 1b <b>D.O.A.</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>St. Louis City Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>4041 N. Newstead Ave.,</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>J.</b> Last <b>GROSS</b>			4. DATE OF DEATH Month <b>August</b> Day <b>12,</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9-1-1886</b>	9. AGE (last birthday) <b>72</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Disability - Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Majestic Range Company</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>George Gross</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Levine</b>		14. NAME OF HUSBAND OR WIFE		
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>-</b>		17. INFORMANT Address <b>Mrs. Kate Hill - 4041 No. Newstead Ave.</b>		

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
IMMEDIATE CAUSE (a) <b>Cardiac Decompensation</b>		<b>2 weeks</b>
DUE TO (b) <b>Arterio sclerotic Heart Disease</b>		<b>years</b>
DUE TO (c) <b>Fecal Impaction</b>		<b>2 weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days.
<b>Ascites, Urinary retention, Malnutrition, Abdominal Tumor</b>		<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 COUNTY STATE

21. I attended the deceased from **8-4-59** to **8-7-59** and last saw him alive on **8-7-59**  
Death occurred at **10:00 A** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>John V. Lawrence</b>	22b. ADDRESS <b>MD 3720 Washington Ave St Louis</b>	22c. DATE SIGNED <b>8-12-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>August 14, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>
23d. LOCATION (City, town, or county) <b>St. Louis, Missouri</b>		

24. FUNERAL DIRECTOR ADDRESS <b>Math Hermann &amp; Son, Inc., 2161 E. Fair</b>	25. DATE RECD. BY LOCAL REG. <b>AUG 12 '59</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith M.D.</b>
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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 \_\_\_\_\_

*Walter M. King*

Licensed Embalmer No. 373

P. O. Address St. Louis

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.