

OURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 5 4 9 1

FILED VS DEC 3 0 1959

211377

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

AMENDED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY St. Louis				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 2 Weeks		c. CITY OR TOWN St. Johns		Inside Limits Yes # No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Johns Hospital			Inside Limits Yes # No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3418 Lindscott		Reside on Farm Yes <input type="checkbox"/> No # <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ethel Middle A. Last Gruelle				4. DATE OF DEATH Month Dec. Day 7, Year 1959				
5. SEX Female	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 11/17/1891	9. AGE (last birthday) 68	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) At Home		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME Edward Bray			13b. MOTHER'S MAIDEN NAME Catherine Finnerty			14. NAME OF HUSBAND OR WIFE Lester E. Gruelle		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Lester E. Gruelle, 3418 Lindscott				
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>Cerebro-Vasc. accident</i> DUE TO (b) <i>Arterio Sclerosis</i> DUE TO (c) <i>331x</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Hypertension, Heart Failure Diabetes mellitus</i>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 <i>July 1957</i> to <i>Dec 7, 1959</i> and last saw her/him live on <i>Dec 7, 1959</i> Death occurred at <i>3:05 pm</i> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <i>R. F. Huck, MD</i> (Degree or title)				22b. ADDRESS <i>9216 Clayton Rd</i>		22c. DATE SIGNED <i>Dec 8, 1959</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/10/1959	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) St. Louis, Mo.				
24. FUNERAL DIRECTOR Collier Mortuary, St. Ann, Mo.			25. DATE RECD. BY LOCAL REG. DEC 8 1959		26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

315 St. Paul & West
9216 Clayton Rd.

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 Sheldon C. Collier

Licensed Embalmer No. 3382

P. O. Address St. Ann's

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.