

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH - 61-026855

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6876 STATE FILE NUMBER

FILED AUG 3 1961

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Texas</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>11-days</b>	c. CITY OR TOWN <b>Houston</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>BARNES HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1515 Bissonnett</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>E.</b> Last <b>Gross</b>			4. DATE OF DEATH Month <b>7</b> Day <b>23</b> Year <b>61</b>			
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5/5/1908</b>	9. AGE (last birthday) <b>53</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>Adv. Agnet</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Webster Groves, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	
13a. FATHER'S NAME <b>Robert H. Gross</b>		13b. MOTHER'S MAIDEN NAME <b>Adelaide Anderson</b>		14. NAME OF HUSBAND OR WIFE <b>Mes. Elizabeth C. Gross</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, if unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>World War # 2</b>	17. INFORMANT Address <b>Mrs. Elizabeth C. Gross, 1515 Bissonnett</b>			
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 infarction</b> <b>Cerebral infarction</b> <b>diabetes mellitus</b> <b>Diabetes Mellitus</b>			Hogston, Texas.		INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>unknown</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			<b>260x</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	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <b>7/13/61</b> to <b>7/23/61</b> and last saw her <b>7/23/61</b> Death occurred at <b>7/23/61 12:30 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <b>F.R. Bradley M.D.</b> Dr. F. R. Bradley		22b. ADDRESS <b>BARNES HOSPITAL</b>		22c. DATE SIGNED <b>7/24/61</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>7/25/1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) <b>St. Louis, Missouri</b>		(State)	
24. FUNERAL DIRECTOR <b>Arthur J. Donnelly</b>		ADDRESS <b>3840 Lindell Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>JUL 24 1961</b>	26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>		

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

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 me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Francis Williamson

Licensed Embalmer No. 3565  
P. O. Address 3840 Lude

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.