

MISSOURI DIVISION OF PUBLIC HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

-61-030777

AMENDED

FILED AUG 23 1961

Primary Registration District No.

Registrar's No.

7392

STATE FILE NUMBER

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</b>		Length of stay in 1b	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Anthony Hospital</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4041 Flora Pl.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>W.</b> Last <b>GROSS</b>			4. DATE OF DEATH Month <b>Aug.</b> Day <b>7</b> Year <b>1961</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>9-22-1870</b>	9. AGE (last birthday) <b>90</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). <b>Agent (Retired) Metropolitan Life Ins. Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Carrollton, Ill.</b>	11. BIRTHPLACE (City and state or country) <b>U.S.A.</b>	12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME <b>John L. Gross</b>		13b. MOTHER'S MAIDEN NAME <b>Margaret Bechtold</b>		14. NAME OF HUSBAND OR WIFE <b>Late Margaret M. Gross</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No None</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>George J. Gross 2003 Maury Ave.</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>Rupture of urinary bladder</b> DUE TO (b) <b>obstructive uropathy</b> DUE TO (c) <b>Prostatic Hypertrophy</b>					INTERVAL BETWEEN ONSET AND DEATH
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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>July 20, 1961</b> to <b>Aug 7, 1961</b> and last saw her/him alive on <b>Aug 7, 1961</b> Death occurred at <b>6:05 P.</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>E. A. Powell M.D.</b>			22b. ADDRESS <b>6500 Chippewa</b>		22c. DATE-SIGNED <b>8-14-61</b>
23a. BURIAL CREATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Aug. 10, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) <b>St. Louis, Mo.</b>		(State)
24. FUNERAL DIRECTOR <b>Kriegshauser 4228 S. Kingshighway Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>8-9-1961</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>		

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
DATE AMENDED  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF  
ITEM NO. SHOULD READ

**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 William B White

Licensed Embalmer No. 4291

P. O. Address \_\_\_\_\_

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.