

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-035287
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 542 Registrar's No. 2448

AMENDED

FILED SEP 19 1961

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Ferguson		Length of stay in 1b 3 Weeks	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Halls Ferry Nursing Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1032 Veronica Avenue, 15 Residence on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First LYDIA Middle JULIA Last GROSS	4. DATE OF DEATH Month August Day 29 Year 1961.
---	---

5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-30-1878	9. AGE (last birthday) 82	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) Housework	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY USA
---	--	--	---

13a. FATHER'S NAME Robert Mueller	13b. MOTHER'S MAIDEN NAME Hannah Lange	14. NAME OF HUSBAND OR WIFE Late Christ Gross
---	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Address Mrs. Marie Mc Allister, 1032 Veronica Ave. (15)
---	--	---

18. CAUSE OF DEATH (Enter only one cause per (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma sigmoid DUE TO (b) Metastatic Carcinoma Liver DUE TO (c) 153.3		INTERVAL BETWEEN ONSET AND DEATH 3 months
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 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 St. Louis COUNTY St. Louis STATE Missouri
--	--	--	--

21. I attended the deceased from death occurred July 24/61 to Aug 29/61 and last saw her alive on Aug 28/1961 Death occurred Aug 29 3:00 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE J. J. Felling (Degree or title) M.D.	22b. ADDRESS 8321 No Broadway	22c. DATE SIGNED 8/31/61
--	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-1-61	23c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery	23d. LOCATION (City, town, or county, state) St. Louis County, Missouri
--	----------------------------	---	---

24. FUNERAL DIRECTOR CALVIN F. FEUTZ, 4828 Natural Bridge Blvd., FUNERAL HOME, St. Louis, 15, Missouri.	25. DATE RECD. BY LOCAL REG. 8-31-61	26. REGISTRAR'S SIGNATURE J. J. Felling M.D.
---	--	--

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 Robert E. Mullens

Licensed Embalmer No. 4916
P. O. Address St. Louis, Mo.

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.