

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-009147

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 651 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

14003

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. <del>DECLARED</del> <b>MAR 15 1962</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
a. COUNTY <b>St. Louis</b>		a. STATE <b>Mo.</b>	b. COUNTY <b>St. Louis</b>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kirkwood 22, Missouri</b>		c. CITY OR TOWN <del>St. Louis, Missouri</del>	
Length of stay in 1b <b>3 hours</b>		d. STREET ADDRESS (If outside, give location) <b>5813 Grace Avenue</b>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Joseph's Hospital</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First <b>Ronald</b>	Middle <b>William</b>	Last <b>Grau</b>	Month <b>February</b> Day <b>21</b> Year <b>1962</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>2-8-39</b>
9. AGE (last birthday) <b>23</b>		IF UNDER 1 YEAR Months <b>23</b> Days <b></b>	IF UNDER 24 HR Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>United Parcel</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>Adolph Grau</b>	
13b. MOTHER'S MAIDEN NAME <b>Leona Gofforth</b>		14. NAME OF HUSBAND OR WIFE <b>Gerlinde Grau</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes 17-56 to 6-60</b>		16. SOCIAL SECURITY NO. <b>7-56 to 6-60</b>	
17. INFORMANT <b>Mrs. Gerlinde Grau</b>		Address <b>5813 Grace 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>Multiple injuries, shock and hemorrhage</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____			
DUE TO (c) _____			
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 type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <b>Lost control of car which rolled over several times, throwing deceased from vehicle</b>	
20c. TIME OF INJURY <b>9:20</b> Hour <b>XXXX</b> Month, Day, Year <b>2/21/62</b> p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>highway</b>	20f. CITY, TOWN, OR LOCATION <b>Jefferson</b> COUNTY <b>Missouri</b> STATE
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____			
Death occurred at <b>11:45</b> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Raymond Harris</i> (Degree or title) <b>Coroner</b>		22b. ADDRESS <b>Clayton, Mo.</b>	22c. DATE SIGNED <b>2/27/62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>2-24-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Trinity</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>
24. FUNERAL DIRECTOR <b>HOFFMEISTER COLONIAL MORTUARY</b> ADDRESS <b>SAM</b>	25. DATE RECD. BY LOCAL REG. <b>2-23-62</b>	26. REGISTRAR'S SIGNATURE <i>John C. Murphy M.D.</i>	
6464 Chippewa (Licensed Embalmer's Statement on Reverse Side)			

**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 *Eric C. Branson*

Licensed Embalmer No. *4764*

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.