

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-044289

11787

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. _____

FILED DEC 14 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

DOCUMENT

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4116 West Green Lea</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>4116 West Green Lea</u>				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CAROLINE</u> Middle <u>J</u> Last <u>GROTE</u>						4. DATE OF DEATH Month <u>December</u> Day <u>8th</u> Year <u>1962</u>					
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>10/3/69</u>		9. AGE (last birthday) <u>93</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (City and state or country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13a. FATHER'S NAME <u>Henry Liliensiek</u>				13b. MOTHER'S MAIDEN NAME <u>Louise Poeggemoeller</u>				14. NAME OF HUSBAND OR WIFE <u>William Grote</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Ida Grote, 4116 West Green Lea</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>										INTERVAL BETWEEN ONSET AND DEATH: <u>3 hrs</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u>											
DUE TO (c) <u>331x</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>none</u>								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.) <u>none</u>							
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year <u>none</u>											
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.) <u>none</u>		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE			
21. I attended the deceased from <u>June 1960</u> to <u>Dec 8 62</u> and last saw her/him alive on <u>Dec 7 62</u> Death occurred at <u>2:45</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) <u>M. P. Stechle</u>						22b. ADDRESS <u>7124 Natural Bridge</u>			22c. DATE SIGNED <u>12/10/62</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		23b. DATE <u>12/11/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Salem Ev. Lutheran Cemetery</u>		23d. LOCATION (City, town, or county) <u>St. Louis Co., Mo.</u>		(State)			
24. FUNERAL DIRECTOR ADDRESS <u>DIEDRICH FUNERAL HOME, 8319 Hallsferry</u>						25. DATE RECD. BY LOCAL REG. <u>DEC 10 1962</u>		26. REGISTRAR'S SIGNATURE <u>Roan Smith, M.D.</u>			

USE BLACK INK OR TYPEWRITER RIBBON

STATE OF MISSOURI

DEPARTMENT OF HEALTH

CERTIFICATE

OF DEATH

Number of days since death

x

Number of days since death

Name of deceased

Age

Sex

Color

Sex

Color

Age

x

Color

Age

Name

Address

City

Place of death

Time of death

Place of death

Name of physician

Address

City

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 M. Murray

Licensed Embalmer No. 3749

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.

Exhibit