

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

32606
Do not use this space.

1. PLACE OF DEATH

(a) County.....
 (b) Township.....
 (c) City.....
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2
1
791
1003
St. Louis Mo. (d) Street No. 4128 A Cleveland Ave

2. PRINT FULL NAME

(a) Residence, No. 4128 A Cleveland Ave St. 17
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 29 1918

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
 18 8 15

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. College Student
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation.

12. BIRTHPLACE (CITY OR TOWN) St. Louis Mo. (STATE OR COUNTRY)

FATHER 13. NAME Albert F. Groebä

14. BIRTHPLACE (CITY OR TOWN) Germany (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Mabel Pfaff

16. BIRTHPLACE (CITY OR TOWN) St. Louis Mo. (STATE OR COUNTRY)

17. INFORMANT Albert Groebl (ADDRESS) 4128 A Cleveland Ave

18. BURIAL, CREMATION, OR REMOVAL PLACE S.S. Peter & Paul Sept 17 37

19. FUNERAL DIRECTOR (ADDRESS) 2906 Gravois Ave. (Signature: Thos Kutas)

20. FILED (Signature: Buddeck) Local Registrar. SEP 15 1937

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9/14 1937

22. I HEREBY CERTIFY, That I attended deceased from 9/4 1937 to 9/14 1937. I last saw him alive on 9/13/37. Death is said to have occurred on the date stated above, at 12:30 a.m. The principal cause of death and related causes of importance were as follows:

Acute Gastro-intestinal infection. Date of onset 9/3/37. Other contributory causes of importance: none.

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____. Where did injury occur? _____ (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____
 (Signed) _____ M. D.
 (Address) _____

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

10-000

STATEMENT BY LICENSED EMBALMER

I, THOS. KUTIS, Licensed Embalmer No. 1619

hereby certify that the body recorded on the reverse side of this certificate was embalmed by

THOS. KUTIS L. E. 1619

No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed

Thos Kutis

Licensed Embalmer No. 1619

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.)