

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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

8774  
Do not use this space.

APR 12 1939

**1. PLACE OF DEATH**

(a) County ..... Registration District No. **791**  
 (b) Township ..... Primary Registration District No. **1003**  
 (c) City **St. Louis** (d) Street No. **City Hospital No. 1** St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (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. PRINT FULL NAME**

(a) Residence, No. **4250 Bates** St. **1** (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX **female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED **married**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **March 16, 1890**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
**49 0 0**

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **California**

FATHER 13. NAME **Paul Kohly**

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

MOTHER 15. MAIDEN NAME **Elizabeth Lutz**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Germany**

17. INFORMANT **Hosp. Info M. Kent**  
 (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE **St. Marcus** DATE **Mar. 20, 1939**

19. FUNERAL DIRECTOR (NAME) **Wacker-Heldendae**  
 (ADDRESS) **2331 S. Broadway**

20. FILED **MAR 17 1939** **J. P. Beckwith** Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **3/16/39**

22. I HEREBY CERTIFY That I attended deceased from **2/15/39** to **3/16/39**  
 I last saw her alive on **3/16/39**. Death is said to have occurred on the date stated above, at **5.15 p.m.**  
 The principal cause of death and related causes of importance were as follows:

*Lobar Pneumonia  
 Diabetes Mellitus*

Other contributory causes of importance:

Name of operation **None** Date of.....  
 What test confirmed diagnosis?..... Was there an autopsy? **yes**

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?.....  
 If so, specify.....  
 (Signed) **Jes. J. Davis**, M. D.  
 (Address) **City Hospital No. 1**

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.....

*Frank J. Hyland Sr.*

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*Frank J. Hyland Sr.*

Licensed Embalmer No.....

P. O. Address.....

*No 45*  
*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 this body is not embalmed, above space should be left blank.**