

AUG 11 1939

791
1003

STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **6327**

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Luthern Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 Days
In this community All his life (Specify whether years, months or days) 55-11-16

3. (a) PRINT FULL NAME Joseph Herman Grohe 6511

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive -- years

7. Birth date of deceased July 30, 1883
(Month) (Day) (Year)

| | | | | |
|---------|-------|--------|------|----------------------|
| 8. AGE: | Years | Months | Days | If less than one day |
| | 55 | 11 | 16 | hr. _____ min. |

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Brewer

11. Industry or business Faul Staff Brewery

12. Name Joseph F. Grohe

18. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Magdalena Braun

15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Adolphus F. Grohe

(b) Address 600 W. 7th St. Centralia, IL

17. (a) Burial (b) Date thereof 7/19/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews

18. (a) Signature of funeral director Wacker-Hildebrand

(b) Address 2331 S. Broadway

19. (a) Jul 18 1939 (b) J. F. Beudick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 14
(If outside city or town limits, write "RURAL")
(d) Street No. 3440 Halliday
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 15
year 1939 hour 7 minute 40 p.m.

21. I hereby certify that I attended the deceased from July 15, 1939 to July 15, 1939
that I last saw alive on July 15, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Embolism
+ Spinae
Due to Primary seat Unknown

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 47

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury 1

23. Signature Robert Grode (M. D. or other)
Address 3115 S. Grand Date signed 7/17/39

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

Handwritten notes, possibly including "No. 10" and "1/21/19" followed by illegible cursive text.

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.....

....., Registered Apprentice No.
working under my personal supervision.

Signed Frank J. Howard Sr.
Licensed Embalmer No. 2645
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 this body is not embalmed, above space should be left blank.