

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 537
Registrar's No. 537

Registration District No. 701 Primary Registration District No. 1000

1. PLACE OF DEATH: 1000
(a) County St. Louis
(b) City or town St. Louis
(c) Name of hospital or institution: 3120 Gurney Ave
(d) Length of stay: In hospital or institution None
In this community Unknown

3. (a) PRINT FULL NAME Katherine Obrock
3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife C.H. Obrock Decased 6. (c) Age of husband or wife if alive ----- years
7. Birth date of deceased 2-7-1868

8. AGE: Years 71 Months 11 Days 11 If less than one day hr. min.

9. Birthplace St. Louis Missouri

10. Usual occupation At home

11. Industry or business ---

12. Name Charles Grambs
13. Birthplace Germany
14. Maiden name Mary Johanningmeier
15. Birthplace Germany

16. (a) Informant's own signature Mrs Louise Grambs
(b) Address 3120 Gurney Ave
17. (a) Burial (b) Date thereof 1/20/40
(c) Place: burial or cremation Friedens cemetery

18. (a) Signature of funeral director Math Hermann & Son
(b) Address 2161 East Fair Ave
19. (a) JAN 19 1940 (b) [Signature]

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County ---
(c) City or town St. Louis
(d) Street No. 3120 Gurney Ave
(e) If foreign born, how long in U. S. A. ? --- years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 18th
year 1940 hour 7:30 AM minute --- M.

21. I hereby certify that I attended the deceased from July 15, 1939, to Jan 18, 1940
that I last saw her alive on Jan 18, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis Duration 1 yr

Due to ---

Due to ---

Other conditions ---
(Include pregnancy within 3 months of death)

Major findings: Of operations no operation

Of autopsy no 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 ---

23. Signature [Signature] (M. D. or other) ---
Address 2919 D. King highway Date signed 1/19/40

PHYSICIAN
Underline the cause to which death should be charged statistically

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.

FORM 1 X1931

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 *Henry Hampton*

Licensed Embalmer No. *2967*

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.