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SEP 20 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

27131

State File No. _____

Registration District No. **791**

Primary Registration District No. _____

Registrar's No. **7027**

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: **St. John's Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **39 day's**
In this community **73 Years** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Christine M. Grupe**
3. (b) If veteran, name war **No**
3. (c) Social Security No. **No**

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

6. (b) Name of husband or wife **Edward F. Grupe**
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **June 24, 1867**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	73	1	25	hr. _____ min. _____

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

10. Usual occupation **Housework**

11. Industry or business _____

12. Name **Unknown**

13. Birthplace **"**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

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

16. (a) Informant **Harry L. Grupe**

(b) Address **4019 Fair Ave.,**

17. (a) **Burial** (b) Date thereof **Aug. 21, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Valhalla Cemetery**

18. (a) Signature of funeral director **M. T. Paschedag**

(b) Address **2825 N. Grand Blvd.**

19. (a) **AUG 19 1940** (b) _____
(Date of local registration) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis** **10**
(If outside city or town limits, write "RURAL")
(d) Street No. **4019 Fair Ave.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **19th**
year **1940** hour **1** minute **15 A** M.

21. I hereby certify that I attended the deceased from **July 10** 19**40** to **August 19** 19**40**
that I last saw h. **ex** alive on **August 18** 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral vascular disease with probable hypertensive stroke with left hemiplegia**
Due to _____
Due to _____

Other conditions **Dilated Myelitis cysticis Pyelitis**

Major findings: Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

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 **E. A. Munsch M.D.** (M. D. or other)

Address **St. John's Hosp.** Date signed **8/19/40**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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

Guy W. Wilkinson

Licensed Embalmer No.

3575

P. O. Address

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.