No.
-17-39
I X21492

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

FILED MAY 9 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 13673

Registration District No. 760A Primary Registration District No. 5999 Registrar's No.

1. PLACE OF DEATH:

(a) County ST. CHALES Corner Tr. Mo

(b) ~~City or town~~ O'FALLON RURAL
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether
In this community ____ years, months or days)

2. USUAL RESIDENCE OF DECEASED: 92

(a) State MISSOURI (b) County ST. CHARLES

(c) City or town O'FALLON MO RURAL
(If outside city or town limits, write "RURAL")

(d) Street No. ROUTE 3
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME HENRY M. GRIESBAUER

3. (b) If veteran; name war —

3. (c) Social Security No. —

4. Sex MALE 0

5. Color or race WHITE

6. (a) ~~Single~~, widowed, ~~married~~, ~~divorced~~ 2

6. (b) Name of ~~husband~~ or wife CARRIE GRIESBAUER

6. (c) Age of husband or wife if alive — years

7. Birth date of deceased APRIL (Month) 6 (Day) 1857 (Year)

8. AGE:

Years	Months	Days	If less than one day
84	0	2	— hr. — min.

9. Birthplace ST PAUL (City, town, or county) — 1 (State or foreign country)

10. Usual occupation FARMER

11. Industry or business —

FATHER
12. Name GRIESBAUER
13. Birthplace — (City, town, or county) GERMANY (State or foreign country)

MOTHER
14. Maiden name NOT KNOWN
15. Birthplace (City, town, or county) GERMANY (State or foreign country)

16. (a) Informant FRANK GRIESBAUER
(b) Address O'FALLON MO R 3

17. (a) ____ (Burial, ~~cremation, or removal~~) (b) Date thereof APRL (Month) 11 (Day) 1941 (Year)
(c) Place: burial or ~~cremation~~ ST. PAUL MO

18. (a) Signature of funeral director E. A. Kittly
(b) Address O'Fallon Mo

19. (a) May 3/41 (Date received local registrar) (b) Gertrude S. Forsteer (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 8
year 1941 hour 4 minutes 30 P M.

21. I hereby certify that I attended the deceased from 4-4-41 ~~4-8-1941~~ to 4-8, 1941;
that I last saw him alive on 4-7, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Paralysis (Hemiphlegia) — Duration

Due to Arterial Sclerosis

Due to Old Age

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

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
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) no
(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? —
(Specify type of place)
While at work? — (e) Means of injury —

23. Signature P. C. Neunlist (M. D. or other)
Address Old Monroe Mo Date signed 4-9-41

(Licensed Embalmer's Statement on Reverse Side)

832

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 E A Keithly

Licensed Embalmer No. 822

P. O. Address Dallas 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.

No. 2B
—4-25-41
I X27852

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 15673

Registration District No. 760 A Primary Registration District No. 5999 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County St Charles
(b) City or town Cuivre T. P.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Henry M. Brisbauer
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased (Month) (Day) (Year)
8. AGE: Years 84 Months 0 Days 2 If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 8 year 1941 hour minute M.
21. I hereby certify that I attended the deceased from , 19, to , 19; that I last saw him alive on , 19; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Paralysis Hemiplegia
Due to arterial Sclerosis
Due to Cerebral Hemorrhage
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
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 (M. D. or other)
Address Date signed

S-15673