

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

37032

State File No. _____
Registrar's No. **9262**

DEC 22 1941 **791**
Registration District No. _____

Primary Registration District No. **1003**

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

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:
6929 Arthur Ave
(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:
(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **6929 Arthur Ave**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Johanna Cook (Koch)**
(b) If veteran, name war _____ (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Nov** day **21**
year **1941** hour **7 PM** minute **20 P.** M.
21. I hereby certify that I attended the deceased from **Oct 10** 19**41** to **Nov 21** 19**41**
that I last saw him alive on **Nov 21** 19**41**
and that death occurred on the date and hour stated above.

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widowed**
6. (c) Age of husband or wife if alive **49** years
7. Birth date of deceased **April 7 1859**
(Month) (Day) (Year)

Immediate cause of death **Mitral Insufficiency 7 dr**
Duration _____

8. AGE: Years **82** Months **7** Days **14**
If less than one day _____ hr. _____ min.

Due to _____
Due to **Insufficiency of age 5 weeks**
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations **97**
Of autopsy **10-15**

9. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)
10. Usual occupation **At Home**

MOTHER FATHER { 11. Industry or business _____
12. Name **Gottlieb Grefarth**
13. Birthplace **Germany 4**
(City, town, or county) (State or foreign country)
14. Maiden name **Anna Marie Biehler**
15. Birthplace **Germany 4**
(City, town, or county) (State or foreign country)

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant **Joseph Cook**
(b) Address **6929 Arthur Ave**
17. (a) **Burial** (b) Date thereof **Nov 24 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Mt Olive Cemetery**

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? _____

18. (a) Signature of funeral director **Beiderwieden Funl Home Inc**
(b) Address _____
19. (a) **22 1941** (b) **J. F. Bredesk**
(Date received local registrar) (Registrar's signature)

While at work _____ Means of injury **C**
23. Signature **Francis Conway** (M. D. or other) _____
Address **5021 Union Bl** Date signed **11/21/41**

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.....

Licensed Embalmer No..... *3737*

P. O. Address..... *1936 St. Louis Ave*

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, fact should be so stated above.