

FILED JUN 30 1944
Registration District No. 313

Primary Registration District No. 1003

Registrar's No. 5687

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:
Missouri Baptist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 0 (Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Helene Kluender Grolock.

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 Widowed

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

7. Birth date of deceased Feb. 7 1870
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
74 4 16 hr. min.

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

10. Usual occupation At home

11. Industry or business _____

12. Name Frederick Hy. Kluender.

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

14. Maiden name Armantine Eschivard.

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

16. (a) Informant Fritz K. Grolock.

(b) Address 5909 Cates Ave.

17. (a) Cremation (b) Date thereof 6-26-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Crematory

18. (a) Signature of funeral director C.R. Lupton & Sons

(b) Address 7233 Delmar Blvd.

19. (a) JUN 23 1944 (b) J.F. Budeck
(Date received local registrar) (Registrar's signature)

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. 5186 Cabanne Ave. (If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 23rd
year 1944 hour 7:00 minute A. M.

21. I hereby certify that I attended the deceased from May
1944 to June 23, 1944
that I last saw her alive on June 23, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Hepatitis Duration 12 days

Due to Cholelithiasis & Common duct Obstruction 2 mo.

Other conditions Cholelithiasis / 2 mo.
(Include pregnancy within 3 months of death)

Major findings: Cholelithiasis & Common duct Obstruction
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 Paul K. Webb M.D. (M. D. or other) _____
Address 1508 Manual Bldg Date signed 6-23-44

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

2
11
59
26390

CH-6938

Hrs. - 1 to 5 P.M.

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

Clarence H. Murray

Licensed Embalmer No.

40117

P. O. Address

St. Louis

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.