

FILED SEP 30 1944

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29369

State File No. 8082  
Registrar's No.

Registration District No. 318

Primary Registration District No. 1003

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:  
2725 LAFAYETTE  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
In this community.....  
years, months or days

3. (a) PRINT FULL NAME Ella Grefenkamp

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

7. Birth date of deceased Nov. 16, 1886  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
57 10 3 hr. min.

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

10. Usual occupation Housework

11. Industry or business.....

12. Name Timothy J. Ryan

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

14. Maiden name Margaret Walsh

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

16. (a) Informant Mrs. Lillian Martin

(b) Address 5728 Astra Ave.

17. (a) Burial (b) Date thereof 9/22/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director M. W. ...

(b) Address 2117 E. Grand Blvd.

19. (a) SEP 21 1944 (b) J. P. ...  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 17  
(c) City or town St. Louis (If outside city or town limits, write "RURAL") 9 73  
(d) Street No. 2156 Lafayette Ave.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 19  
year 1944 hour 6 minute 05 P.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;  
that I last saw h..... alive on....., 19.....,  
and that death occurred on the date and hour stated above.

Immediate cause of death Systemic venous thrombosis  
from cerebral embolus of right lung  
dissected at the base of neck  
from cerebral artery in floor  
of room of National  
Lafayette Ave. Sept. 19, 1944  
Other conditions see text under  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations None  
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) Homicide  
(b) Date of occurrence Sept. 19, 1944  
(c) Where did injury occur? at home  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
a Place of Business  
While at work? No (Specify type of place) (e) Means of injury see above

23. Signature J. P. ... (M. D. or other).....  
Date signed 9/20/44

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

**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..... *Frank A. Moore* .....

Licensed Embalmer No. *3041* .....

P. O. Address *2117 E. 1st* .....

**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.**