

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36634
2202
Registrar's No. 2202

FILED OCT 29 1947
Registration District No. 3947

Primary Registration District No. 6076

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis Riverview Gardens
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
10018 Sheldon Drive
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 years
In this community 6 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Bernadine (Dena) Grenzer
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 _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased December 15, 1869
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
77 10 4 _____ hr. _____ min.

9. Birthplace Highland Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business at home

FATHER { 12. Name Clement Ull
13. Birthplace Germany 4
(City, town, or county) (State or foreign country)
MOTHER { 14. Maiden name Adeline Hendricks
15. Birthplace Germany 4
(City, town, or county) (State or foreign country)

16. (a) Informant J. Granger
(b) Address Madison, Illinois

17. (a) Rem. to Madison (b) Date thereof 10/19/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Edwards Hill

18. (a) Signature of funeral director Francis J. Kelly
(b) Address Madison, Illinois

19. (a) 10-22-47 (b) Carol R. Shapley
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis 96
(c) City or town St. Louis Riverview Gardens 0
(If outside city or town limits, write "RURAL") b
(d) Street No. 10018 Sheldon Drive 0
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 19
year 1947 hour 3 minute 40 A. M.
21. I hereby certify that I attended the deceased from Oct
1, 1945, to Oct 19, 1947
that I last saw her alive on Oct 19, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage 1 day
Duration
Due to Hypertension
Due to Stroke 1 hr
Other conditions Stroke 1 hr
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations: none
Of autopsy: none
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 _____
Signature J. Scopelito (M. D. or other) MD
Address 3718 Grand Date signed 10/21/47

JAN 20 1948

STATE BOARD OF HEALTH
DEPARTMENT OF HEALTH

OCT 31 1943

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 *Francis J. Lahey*
Licensed Embalmer No. *2792*
P. O. Address *Madison Ill.*

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.