

FILED SEP 2 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 28931

7655

|  |  |  |  |  |  |  |                           |  |   |  |
|--|--|--|--|--|--|--|---------------------------|--|---|--|
| BIRTH NO. _____  |  | REG. DIST. NO. <b>318</b>                              |  | PRIMARY REG. DIST. NO. <b>1003</b>   |  | Registrar's No. _____  |                           |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Louis,</b>   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>Missouri</b><br>b. COUNTY _____ |  |  |                           |  |   |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR<br>TOWN <b>St. Louis</b>  |  | c. LENGTH OF STAY (in this place)<br><b>13yr. 250d</b> |  | c. CITY (If outside corporate limits, write RURAL and give township)<br>OR<br>TOWN <b>St. Louis</b>                                  |  | 2129   |                           |  |   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Masonic Hospital</b>  |  |  |  | d. STREET ADDRESS (If rural, give location)<br><b>12 5351 Delmar Bl.</b>   |  |  |                           |  |   |  |
| 3. NAME OF DECEASED<br>(Type or Print) <b>Elizabeth</b>  |  |  | a. (First)   |  | b. (Middle) <b>---</b>   |  | c. (Last) <b>Gruenert</b> |  |   |  |
| 4. DATE OF DEATH <b>Aug. 17, 1954</b>  |  | 5. SEX <b>F</b>  |  | 6. COLOR OR RACE <b>W</b>  |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED <b>W</b>  |                           | 8. DATE OF BIRTH <b>June 22, 1881</b>            |   |  |
| 9. AGE (In years last birthday) <b>73</b>  |  | IF UNDER 1 YEAR<br>Months <b>1</b> Days <b>25</b>      |  | IF UNDER 24 HRS.<br>Hours _____ Mins. _____  |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b> |                           | 10b. KIND OF BUSINESS OR INDUSTRY _____          |   |  |
| 11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo.</b>   |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |  |                           |  |   |  |
| 13a. FATHER'S NAME<br><b>Henry Brewer</b>  |  |  | 13b. MOTHER'S MAIDEN NAME<br><b>Minnie Temme</b>   |  |  | 14. NAME OF HUSBAND OR WIFE<br><b>Julius</b>   |                           |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>  |  |  | 16. SOCIAL SECURITY NO. _____  |  |  | 17. INFORMANT'S SIGNATURE OR NAME<br><b>Mason's Home of Missouri</b>                                       |                           |  |   |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.                                |  |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cardiovascular-renal disease</b>  |  |  |  |                           | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 Mo.</b> |   |  |
| ANTECEDENT CAUSES<br><b>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</b>   |  |  | DUE TO (b) <b>Bronchial asthma</b>   |  |  |  |                           | 3 yrs.   |   |  |
| DUE TO (c) _____   |  |  | II. OTHER SIGNIFICANT CONDITIONS:<br><b>Conditions contributing to the death but not related to the disease or condition causing death. Bronchial Asthma</b> |  |  |  |                           | 3yr.   |   |  |
| 19a. DATE OF OPERATION _____   |  |  | 19b. MAJOR FINDINGS OF OPERATION _____   |  |  |  |                           |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____   |  |  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____   |  |  | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____  |                           |  |   |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____  |  |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21f. HOW DID INJURY OCCUR?<br><b>442X</b>  |                           |  |   |  |
| 22. I hereby certify that I attended the deceased from <b>July 22, 1954</b> , to <b>Aug. 17, 1954</b> , that I last saw the deceased alive on <b>Aug. 17, 1954</b> , and that death occurred at <b>3:05pm.</b> , from the causes and on the date stated above. |  |  |  |  |  |  |                           |  |   |  |
| 23a. SIGNATURE (Degree or title) _____   |  |  |  | 23b. ADDRESS <b>508 North Grand</b>  |  |  |                           | 23c. DATE SIGNED <b>8-17-54</b>                  |   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>   |  | 24b. DATE <b>8/20/54</b>                               |  | 24c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Cemetery</b>  |  | 24d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo.</b>                                  |                           |  |   |  |
| DATE REC'D BY LOCAL REG. <b>AUG 18 1954</b>  |  | REGISTRAR'S SIGNATURE <b>J. Carl Smith, M.D.</b>       |  |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Drehmann-Harral 1905 Union Blvd.</b> |  |                           |  |   |  |

E.D. (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Warren A. Carver

Licensed Embalmer No. 3534

P. O. Address \_\_\_\_\_

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.