

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **6847**

FILED MAR 8 1955

BIRTH NO.		REG. DIST. NO. 317	PRIMARY REG. DIST. NO. 500	Registrar's No. 313
1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY		
b. CITY OR TOWN Normandy		c. LENGTH OF STAY (in this place) 1 Year 4 Mo	c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Sullivan Nurseing Home		STREET ADDRESS (If rural, give location) 1803 N. Jefferson Ave., 2209		
3. NAME OF DECEASED (Type or Print) CLARA		a. (First) on	b. (Middle) E.	c. (Last) GROTE
4. DATE OF DEATH Feb. 4, 1955		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		
5. SEX Female	6. COLOR OR RACE White	8. DATE OF BIRTH 1872	9. AGE (In years last birthday) 82	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo	
12. CITIZEN OF WHAT COUNTRY? U.S		13a. FATHER'S NAME Unk. Miller		
13b. MOTHER'S MAIDEN NAME Theresa Murphy		14. NAME OF HUSBAND OR WIFE Hermann Grote Dec.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME Marion Pais
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral thrombosis		INTERVAL BETWEEN ONSET AND DEATH 1 wk.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Arteriosclerosis		unknown
DUE TO (c)		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Previous Cerebral Thrombosis		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? 332X 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?
22. I hereby certify that I attended the deceased from June 20, 1953 , to Feb 4, 1955 , that I last saw the deceased alive on Feb 2, 1955 , and that death occurred at 10:25 A.M. , from the causes and on the date stated above.				
23a. SIGNATURE Lewis Littmann M.D.		23b. ADDRESS 8231 Clayton Rd (17)		23c. DATE SIGNED 2/5/55
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Feb. 7, 1955		24c. NAME OF CEMETERY OR CREMATORY Calvary Cem.,
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Jos. W. Clark		
DATE REC'D BY LOCAL REG. 2-7-55		REGISTRAR'S SIGNATURE Herbert R. Donke M.D.		ADDRESS 1125 Hodiamont Ave.,

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

After 3 P.M.
8231 Skyline Rd.

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 _____
Signature of Student Embalmer

Signed Alfred J. Boedeker

Licensed Embalmer No. 266

P. O. Address 1125 Hodiam

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.