

FILED MAR 7 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6545**
1802

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give town(ship)) OR TOWN St. Louis, Missouri		c. CITY (If outside corporate limits, write RURAL and give town(ship)) OR TOWN Creve Couer, 4000	
c. LENGTH OF STAY (in this place) 4 days		d. STREET ADDRESS (If rural, give location) Lindbergh & Olive St. Roads	
d. FULL NAME OF HOSPITAL OR INSTITUTION Bethesda General Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Sophie b. (Middle) _____ c. (Last) Grieb			4. DATE OF DEATH (Month) (Day) (Year) February 18, 1956		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) N.M.	8. DATE OF BIRTH November 11, 1872	9. AGE (In years last birthday) 83	IF UNDER 1 YEAR Months IF UNDER 12 HRS. Hours Mts.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, County, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Conrad Grieb		13b. MOTHER'S MAIDEN NAME Deuser		14. NAME OF HUSBAND OR WIFE XXXXXXXXXXXX	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Wm. Seeger--Chesterfield, Missouri	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia		DUE TO (b) Asteriolephroses renal			2/14-56
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) + arteriosclerosis generalized			2/16-56
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 446X	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) m.	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 **2/14, 1956** to **Feb 18, 1956**, that I last saw the deceased alive on **2-17, 1956**, and that death occurred at **7:45 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) W. A. Powell M.D.		23b. ADDRESS 466 S. Maryland		23c. DATE SIGNED 2/18/56
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 2-21-1956	24c. NAME OF CEMETERY OR CREMATORY St. Pauls Ev. Cemetery	24d. LOCATION (City, town, or county) (State) Olivette, Mo.	

DATE REC'D BY LOCAL REG. FEB 20 1956	REGISTRAR'S SIGNATURE Carl Smith M.D.	ADDRESS 2504 Woodson Rd - Overland - 14 - Mo.
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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

Escar F. Mueller

Licensed Embalmer No.

3039

P. O. Address

Overland 14 Mo

(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.