

Health, Welfare, Public Service

FILED SEP 17 1957

STANDARD CERTIFICATE OF DEATH

335662

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8233

300 -57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hospital		d. STREET ADDRESS (If outside, give location) 318 E. Souldard	
3. NAME OF DECEASED (Type or print) Martha Grebe		4. DATE OF DEATH Month Day Year Sept. 3, 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 18, 1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) Germany
13a. FATHER'S NAME August Hackert		13b. MOTHER'S MAIDEN NAME Mary Unknown	14. NAME OF HUSBAND OR WIFE Andrew J. Grebe
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 Address Mrs. Roy Carter, 424 E. Orchard-Decatur, Ill.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i>			INTERVAL BETWEEN ONSET AND DEATH <i>4 hrs.</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Hypertension</i>			<i>2 hrs.</i>
DUE TO (c) <i>Cerebral sclerosis</i>			<i>3 hrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II. of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <i>A</i>	COUNTY STATE
21. I attended the deceased from <i>July 1954</i> to <i>9-2-57</i> and last saw her alive on <i>9-1-57</i> Death occurred at <i>12 a.m.</i> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>L. F. Murray M.D.</i>		22b. ADDRESS <i>605-A Russell Hwy</i>	22c. DATE SIGNED <i>9-9-57</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>9-3-57</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Local Cemetery</i>	23d. LOCATION (City, town, or County) (State) <i>Decatur, Ill.</i>
24. FUNERAL DIRECTOR ADDRESS <i>Albert H. Hoppe, 4700 Washington Blvd.</i>		25. DATE RECD. BY LOCAL REG. <i>SEP 3 '57</i>	26. REGISTRAR'S SIGNATURE <i>Carl Smith MD</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 Elton H. Remick

Licensed Embalmer No. 4283  
P. O. Address St. Louis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.