

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-020455  
STATE FILE NUMBER

FILED MAY 26 1958

Registration District No. 317 Primary Registration District No. 548 Registrar's No. 1348

1. PLACE OF DEATH a. COUNTY <b>St. Louis, Missouri</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Webster Groves, Mo.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>University City</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Glenwood Clinics</b>		Length of stay in 1b <b>13 days</b>	d. STREET ADDRESS (If outside, give location) <b>812 East Gate</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Max</b> Middle <b>Grossman</b> Last <b>Grossman</b>			4. DATE OF DEATH Month <b>5</b> Day <b>19</b> Year <b>58</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 14, 1890</b>	9. AGE (In years (last birthday)) <b>67</b>	IF UNDER 1 YEAR Months <b>6</b> Days <b>1</b>
IF UNDER 24 HRS. Hours <b>1</b> Min. <b>0</b>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shipping Clerk for Farm. Manf.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm. Manf.</b>		11. BIRTHPLACE (City and state or country) <b>Russia</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>Morris Grossman</b>		13b. MOTHER'S MAIDEN NAME <b>Esther Grossman</b>	
14. NAME OF HUSBAND OR WIFE <b>Bertha Grossman</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>	16. SOCIAL SECURITY NO. <b>Unk.</b>	17. INFORMANT Address <b>Bertha Grossman 812 East Gate</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR ACCIDENT</b>					INTERVAL BETWEEN ONSET AND DEATH <b>30 MIN</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>GENERALIZED ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE.</b>			DUE TO (c) <b>H22.1</b>
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 <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <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 <b>5</b> Month <b>6</b> Day <b>19</b> Year <b>58</b> a.m. <b>20</b> p.m.	20d. INJURY OCCURRED, WHILE AT <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		COUNTY	STATE
21. I attended the deceased from <b>5/6/58</b> to <b>5/19/58</b> and last saw him alive on <b>5/19/58</b> Death occurred at <b>5:20 p</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Edwin N. Schmitt, M.D.</b>			22b. ADDRESS <b>1300 Grant Road</b>		22c. DATE SIGNED <b>5-19-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur.</b>	23b. DATE <b>5/21/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Chesed Shel Emeth</b>		23d. LOCATION (City, town, or county) (State) <b>University City, Mo.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Berger Memorial 4715 W. Pherson</b>		25. DATE RECD. BY LOCAL REG. <b>5-20-58</b>	26. REGISTRAR'S SIGNATURE <b>Herbert R. Danke M.D.</b>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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: *Lawrence J. Dever*

Licensed Embalmer No. *3988*

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