

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027564

FILED VS JUL 22 1959, 7

Registration District No. _____ Primary Registration District No. 547 Registrar's No. 1804

STATE FILE NUMBER

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|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY St. Louis | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY _____ | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Richmond Heights | | c. CITY OR TOWN St. Louis | |
| Length of stay in lb Life | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hospital | | d. STREET ADDRESS (If outside, give location) 405 Washington Blvd. | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) First William Middle A. Last Griesedieck | | | 4. DATE OF DEATH Month July Day 3 Year 1959 | | |
| 5. SEX M. | 6. COLOR OR RACE W. | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 10-13-1892 | 9. AGE (last birthday) 66 | IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vice-Pres. Retired, Western Brewing Corp. | | 10b. KIND OF BUSINESS OR INDUSTRY St. Louis, Missouri | | 12. CITIZEN OF WHAT COUNTRY U.S. | |
| 13a. FATHER'S NAME Henry L. Griesedieck | | 13b. MOTHER'S MAIDEN NAME Anna Kaup | | 14. NAME OF HUSBAND OR WIFE _____ | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) World War # 1 | | 16. SOCIAL SECURITY NO. _____ | | 17. INFORMANT Address Mr. Henry L. Griesedieck, 629 Langton Dr. | |

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| 18. CAUSE OF DEATH (Enter only one cause per line (to (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancerous of Pancreas | | | INTERVAL BETWEEN ONSET AND DEATH 3 mos. 6 mos. |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Obstruction | | | |
| DUE TO (c) _____ | | | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | |
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| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ a.m. _____ p.m. Month, Day, Year _____ | | | | | |

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|---|--|------------------------------|--------------|-------------|
| 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 | COUNTY _____ | STATE _____ |
| 21. I attended the deceased from Jan. 1, 1949 to July 3, 1959 and last saw him alive on July 2, 1959 Death occurred at 5:17 am. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | |

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| 22a. SIGNATURE (Degree, title) James P. Murphy | | 22b. ADDRESS 634 N. Grand Blvd. | | 22c. DATE SIGNED 7-3-59 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE July 6, 1959 | 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | 23d. LOCATION (City, town, or county) (State) St. Louis, Missouri | |

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| 24. FUNERAL DIRECTOR Walter J. Donnelly ADDRESS 3840 Lindell Blvd. | 25. DATE RECD. BY LOCAL REG. 7-5-59 | 26. REGISTRAR'S SIGNATURE John A. Murphy, MD |
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Francis Hillier

Licensed Embalmer No. 356

P. O. Address 3840

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.