

**FEDERAL BUREAU OF INVESTIGATION**  
**FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-041738**

**FILED VS. NOV. 16 1959**

Primary Registration District No. \_\_\_\_\_

Registrar's No. **2 9593**

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St Louis</b> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St Louis Little Rock Hosp Inc</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b> c. CITY OR TOWN <b>Lemay</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>600 Sandra Court</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Gustav</b> Middle <b>Joseph</b> Last <b>De Greeff</b>			<b>4. DATE OF DEATH</b> Month <b>Oct</b> Day <b>18</b> Year <b>59</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>10,8,09</b>	<b>9. AGE</b> (last birthday) <b>50</b>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HR</b> Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Mc Donnell Air Craft</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>St. Louis, Mo.</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>
<b>13a. FATHER'S NAME</b> <b>Joseph H. DeGreeff</b>			<b>13b. MOTHER'S MAIDEN NAME</b> <b>Anna M. Luther</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Lila Ruth Grisham</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			<b>16. SOCIAL SECURITY NO.</b> <b>188-10-9460</b>		<b>17. INFORMANT</b> Address <b>Mrs. Lila Ruth DeGreeff, -600 Sandra Ct.</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemangioma of Bone.</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <b>228x</b>					INTERVAL BETWEEN ONSET AND DEATH _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Pulmonary Hemorrhage</b>					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	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input checked="" type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)				
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>				
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		<b>20f. CITY, TOWN, OR LOCATION</b> _____ <b>COUNTY</b> _____ <b>STATE</b> _____				
<b>21. I attended the deceased from</b> <b>FEB. 1958.</b> to <b>10/18/59</b> and last saw <sup>her</sup> him alive on <b>10/18/59</b> Death occurred at <b>8-10 am</b> on the date stated above, and to the best of my knowledge, from the causes stated.						
<b>22a. SIGNATURE</b> (Degree or title) <i>Charles Kromer, M.D.</i>			<b>22b. ADDRESS</b> <b>1755 So Grand</b>		<b>22c. DATE SIGNED</b> <b>10/19/59</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>removal</b>	<b>23b. DATE</b> <b>10/21/59</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Sunset Burial Park</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>St. Louis County, Missouri</b>		
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>BEIDERWIEDEN F.H.INC. 1936 St.Louis Avenue</b>			<b>25. DATE RECD. BY LOCAL REG.</b> <b>OCT 20 59</b>		<b>26. REGISTRAR'S SIGNATURE</b> <i>Earl Smith. M.D.</i>	

(Licensed Embalmer's Statement on Reverse Side)

FILED  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF

*mja*

**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 Horner H. Jantz

Licensed Embalmer No. 3882

P. O. Address St. Louis

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.