

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-028791

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7183

FILED JUL 31 1962

VS 300	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	DATE AMENDED
Rev. 4/59		
1		
2 <u>20/69</u>		
3		
4 <u>1</u>		
5 <u>2</u>		
6		
7 <u>1</u>		
8 <u>2</u>		
9		
10		
11		
12 <u>75-0</u>	INSTEAD OF	
13		
	DOCUMENT	
	MEDICAL CERTIFICATION	
	SHOULD READ	
	BY AFFIDAVIT OF	

Thomas A. Schneider, M.D.  
USE BLACK INK  
OR  
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Missouri COUNTY		c. CITY OR TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>											
ST. LOUIS, MISSOURI		ST. LOUIS, MISSOURI		60 years		St. Louis				St. Louis													
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>													
ST. LOUIS CITY # 1						5979 Ridge Avenue																	
3. NAME OF DECEASED (Type or print)			First			Middle			Last			4. DATE OF DEATH											
JESSIE			L. GREWE			ILBERY			JULY			16, 1962											
5. SEX		6. COLOR OR RACE		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR											
Female		White		xx		7-30-94		67		Months		Days											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country)				12. CITIZEN OF WHAT COUNTRY											
Housewife				None				Welga, Illinois				U.S.A.											
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE															
Fred Granneman				Amelia Waltemate				Widow															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address											
No				None				None				Mrs. Helen A. Rayfield, 3208 Capehart											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:												INTERVAL BETWEEN ONSET AND DEATH											
IMMEDIATE CAUSE (a)												2 hrs											
Cerebral Vascular Thrombosis																							
DUE TO (b)																							
Generalized Atherosclerosis																							
DUE TO (c)																							
332X																							
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown													
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			Month, Day, Year																	
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 <u>7-5-62</u> to <u>7-16-62</u> and last saw her alive on <u>7-16-62</u>																							
Death occurred at <u>3:50</u> P. on the date stated above, and to the best of my knowledge, from the causes stated.																							
22a. SIGNATURE (Degree or title)						22b. ADDRESS						22c. DATE SIGNED											
Thomas A. Schneider, MD						1515 LAFAYETTE						7-16-62											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county)			(State)											
Burial			7-20-62			Memorial Park Cemetery			St. Louis County, Mo.														
24. FUNERAL DIRECTOR						ADDRESS						25. DATE RECD. BY LOCAL REG.						26. REGISTRAR'S SIGNATURE					
Stock Mortuaries, 2117 E. Grand						JUL 20 1962						Roan Smith, M.D.											

**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 Paul A. Wacker

Licensed Embalmer No. 4787

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.