

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.
 ✓ 20850
 20948
 File No. _____
 Registered No. **5651**
 St. _____ Ward)

1. PLACE OF DEATH

County St. Louis Registration District No. 79H
 Township _____ Primary Registration District No. 1003
 City St. Louis Christian Hospital St. _____ Ward)

2. FULL NAME

(a) Residence. No. 5367 Claxton St. 7 Ward. _____
 (Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (use the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 6 - 1889

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
41 5 4

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Gardener
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) St. Louis Mo.
 (STATE OR COUNTRY)

10. NAME OF FATHER Rudolph Graft

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Denmark
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Helene Meyer

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Thornisand
 (STATE OR COUNTRY)

14. INFORMANT (Address) Rudolph Graft
5367 Claxton St

15. FILED Jan 11 1930 St. Louis REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 10 1930
 17. No Physician attended
 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

that I last saw h_____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Haemorrhage, due to ruptured aorta (spontaneous)

99 B (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Arteriosclerosis (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. H. Murrell, M. D.

6/11 1930 (Address) Deputy Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Calvary Cemetery

DATE OF BURIAL

6-12-1930

20. UNDERTAKER

Strop & Carroll

ADDRESS

Death Office

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

