

WRITE PLAIN!—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

Registration District No. 791

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County JEFFERSON FEB 17 1940

(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
4814 Bessie Ave. 3
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Mary H. Grafeman 6/15

3. (b) If veteran, name war No.

3. (c) Social Security No. No.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Theodore Grafeman

6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased Oct. 25th 1855
(Month) (Day) (Year)

8. AGE: Years 84 Months 3 Days 1 If less than one day _____ hr. _____ min.

9. Birthplace ST. Louis, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business _____

MOTHER FATHER { 12. Name Casper Kersten

13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Louise Klerberg
(City, town, or county) (State or foreign country)

15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Heline Gehring

(b) Address 4814 Bessie Ave.

17. (a) Burial (b) Date thereof 1-29-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Zions Cem.

18. (a) Signature of funeral director H. Lindner Und. Co.

(b) Address 1417 N. Market St.

19. (a) JAN 27 1940 (b) _____
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis 20
(If outside city or town limits, write "RURAL")

(d) Street No. 2517 N. 23rd. St.
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 26
year 1940 hour 12 minute 45 a.m.

21. I hereby certify that I attended the deceased from Mar 13 _____, 1917, to Jan 26 _____, 1940
and that death occurred on the date and hour stated above.

that I last saw h. er alive on Jan 26 _____, 1940

Immediate cause of death

	Duration
<u>Chronic myocarditis</u>	<u>10 yrs</u>
<u>Chronic nephritis</u>	<u>1 year</u>
<u>Chronic arthritis</u>	<u>16 mos</u>
Other conditions <u>none</u>	

(Include pregnancy within 8 months of death)

PHYSICIAN

Major findings: Of operations X

Of autopsy X

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) X

(b) Date of occurrence X

(c) Where did injury occur? X (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? X (Specify type of place) (e) Means of injury lf

23. Signature H. Kullin T. H. H. H. (M. D. or other) 34

Address 3500 N. Grand Date signed 1/27/40

Hinachi
Free 1358. 8-9-47m.

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Homer L. Ponder
Licensed Embalmer No. 3367
P. O. Address 2223 St. Louis av

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 this body is not embalmed, above space should be left blank.

24-16