DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 16782

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 4260

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution: Christian Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Hospital (Specify whether
In this community 12 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Valley Park N.R.
(If outside city or town limits, write "RURAL")

(d) Street No. Box 242
(If rural, give location)

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

3. (a) PRINT FULL NAME Ralph Edmund Graves 612

3. (b) If veteran, name war

3. (c) Social Security No. 494-09-6372

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Mary Witte Graves

6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased December 5 1887
(Month) (Day) (Year)

8. AGE: Years 52 Months 5 Days 7 If less than one day hr. min.

9. Birthplace Sunderland (City, town, or county) Vermont (State or foreign country)

10. Usual occupation Motion Picture Operator

11. Industry or business

FATHER
12. Name James A. Graves
13. Birthplace (City, town, or county) Vermont (State or foreign country)

MOTHER
14. Maiden name Louisa Graves
15. Birthplace (City, town, or county) Vermont (State or foreign country)

16. (a) Informant's own signature Mary Graves
(b) Address Bx 242 Valley Park, Mo.

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof May 14, 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Valhalla Crematory

18. (a) Signature of funeral director Foster Kron Funeral Home
(b) Address 4911 Washington Bl.

19. (a) MAY 13 1940 (Date received local registrar) (b) J. F. Bredwick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 12
year 1940 hour 6 minute a M.

21. I hereby certify that I attended the deceased from 4/26/40, 19 to 5/12, 1940
that I last saw him alive on 5/11, 1940
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Uremic poisoning	
Acute nephritis	
Due to: following removal	
Due to: of gall bladder	
and appendix	
Other conditions at Christian Hospital (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
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) —
(b) Date of occurrence —
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? —
(Specify type of place)
While at work? — (e) Means of injury

23. Signature J. W. Shaw (M. D. or other)
Address Pasteur Med Bldg Date signed 5/12/40

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—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.

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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 Thomas R. Fenwick

Licensed Embalmer No. 3793

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