

STANDARD CERTIFICATE OF DEATH

State File No. **30348**

Registration District No. **7912**

Primary Registration District No. **1003**

Registrar's No. **7625**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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:  
St. John's Hosp.  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
 In this community 36 yrs  
years, months or days)

3. (a) PRINT FULL NAME Sarolta Graff

8. (b) If veteran, name war no 8. (c) Social Security No. no

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Emil Graff 6. (c) Age of husband or wife if alive (unk) years

7. Birth date of deceased Sept. 10, 1873  
(Month) (Day) (Year)

8. AGE: Years 66 Months 16 Days 26 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation at home

11. Industry or business \_\_\_\_\_

12. Name Samuel Kohn

18. Birthplace Hungary  
(City, town, or county) (State or foreign country)

14. Maiden name Rebecca Klein  
 15. Birthplace Hungary  
(City, town, or county) (State or foreign country)

16. (a) Informant Emil Graff

(b) Address 714 Limit

17. (a) burial (b) Date thereof 9/11/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bnai Amoona

18. (a) Signature of funeral director H.B. Berger

(b) Address 715 McPherson

19. (a) SEP 11 1940 (b) J.P. Sebeck  
(Date received in office) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_

(c) City or town University City  
(If outside city or town limits, write "RURAL")

(d) Street No. 714 Limit  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 36 yrs. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 10  
 year 1940 hour 11 minute 20 a. m.

21. I hereby certify that I attended the deceased from June 1939  
 \_\_\_\_\_, 19\_\_\_\_ to Sept. 10, 1940

that I last saw her alive on Sept. 10, 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death Ch. Cholecystitis  
Ch. Cholecystectomy  
No stones

Duration of illness 4 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Coronary Arteriosclerosis  
(Include pregnancy within 3 months of death)

Major findings: Ch. Cholecystitis

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)

(e) While at work? \_\_\_\_\_ (f) Means of injury \_\_\_\_\_

23. Signature J.P. Sebeck (M. D. or other) M.D.  
 Address 715 McPherson Date signed Sept 10-40

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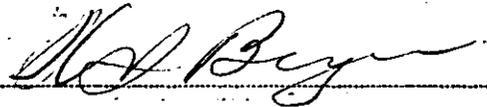
**STATEMENT BY LICENSED EMBALMER**

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.....



.....  
Licensed Embalmer No. ....

P. O. Address .....

**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.**