No. 2
I—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 19 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

35697

State File No. 0

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 2281

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: Veterans' Administration Facility, (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Adm. 8-4-43 (Specify whether years, months or days)

In this community Unkn.

2. USUAL RESIDENCE OF DECEASED: 000

(a) State Missouri (b) County St. Louis 17

(c) City or town - (If outside city or town limits, write "RURAL") 9

(d) Street No. 10098 Sheldon Dr., (If rural, give location)

(e) Citizen of foreign country? - No (Yes or No)

If yes, name country /

3. (a) PRINT FULL NAME GRANER, Robert W.

3. (b) If veteran, name war W.W. #1

3. (c) Social Security No. 491-12-6077

4. Sex Male

5. Color or race White

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

6. (b) Name of ~~husband~~ or wife Florence

6. (c) Age of ~~husband~~ or wife if alive 56 years

7. Birth date of deceased May (Month) 13, (Day) 1887 (Year)

8. AGE: Years 56 Months 4 Days 26 If less than one day ___ hr. ___ min.

9. Birthplace St. Louis, Missouri. (City, town, or county) (State or foreign country) 0

10. Usual occupation WPA Worker.

11. Industry or business - -

FATHER
12. Name John Graner,
13. Birthplace (City, town, or county) Germany (State or foreign country) 4

MOTHER
14. Maiden name Louise Kellman,
15. Birthplace St. Louis, (City, town, or county) Missouri. (State or foreign country) 0

16. (a) Informant M. Stilley Clinical Clerk,

(b) Address V.A.F., Jeff. Brks., Mo.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Oct. 11-43 (Month) (Day) (Year)

(c) Place: burial or cremation NATIONAL CEMETERY

18. (a) Signature of funeral director C. Armeister U.L.Co.

(b) Address 7814 S. Broadway

19. (a) OCT 11 1943 (Date received local registrar) (b) C. S. McGarvon, M.D. (Registrar's signature)

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MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 9th year 1943 hour 5:25 minute A. M.

21. I hereby certify that I attended the deceased from August 4, 1943, to October 9, 1943; that I last saw him alive on October 9, 1943, and that death occurred on the date and hour stated above.

Immediate cause of death Rheumatic heart disease with myocardial damage, mitral and aortic valvular damage, dyspnea and ~~xxxx~~ weakness. Duration Unkn.

95b

Due to

Other conditions Disease of aorta, arteriosclerotic (Include pregnancy within 3 months of death) with aneurism, saccular ascending aorta.

Major findings:
Of operations None
Of autopsy No autopsy

PHYSICIAN Unkn. 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) No

(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? (Name of injury)

23. Signature L. M. COCHRAN, Chief Medical Officer (M. D. or other)

Address J.B., Mo. Date signed 10-9-43

(Licensed Embalmer's Statement on Reverse Side)

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 Linus C. Hoffmeister, Registered Apprentice No. ....., working under my personal supervision.

Signed Linus C. Hoffmeister

Licensed Embalmer No. 3871

P. O. Address 148 Broadway

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, fact should be so stated above.