S. No. 2
M—2-43
r. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 14 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25685

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7839

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: 3724 Michigan Avenue 0
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 600
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 3724 Michigan Ave. 9 16
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Andrew Graf

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male 0

5. Color or race White

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

6. (b) Name of husband or wife Cecelia

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

7. Birth date of deceased Nov. (Month) 28 (Day) 1858 (Year)

8. AGE: Years 86 Months 9 Days 7 If less than one day hr. min.

9. Birthplace (City, town, or county) Germany 11 (State or foreign country)

10. Usual occupation Retired

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace (City, town, or county) Unknown 9 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace (City, town, or county) Unknown 9 (State or foreign country)

16. (a) Informant John Graf
(b) Address 4001 Gustine

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sep. 8, 1945. (Month) (Day) (Year)
(c) Place: burial or cremation New St. Marcus Cemetery

18. (a) Signature of funeral director Wacker-Helderle
(b) Address 3634 Gravois Avenue

19. (a) SEP 7 1945 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 5
year 1945 hour 3 minute 30 P.M.

21. I hereby certify that I attended the deceased from June 2, 1945, to Sept 5, 1945, that I last saw him alive on Sept 5, 1945, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Carcinoma of Oesophagus	4 mo.
Due to: Unknown	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	

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Major findings:
Of operations none
Of autopsy none

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 Julius Chas Rotter M.D. (M. D. or other) MD.
Address 2603 Cherokee St. Date signed

(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 .....

....., Registered Apprentice No. .....,

working under my personal supervision.

Signed Robert Wheeler

Licensed Embalmer No. 2128

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, fact should be so stated above.