No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

FILED OCT 16 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 34763

Registration District No. 367 Primary Registration District No. 6076 Registrar's No. 2880

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
1150 St. Louis Street
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community 30 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 96

(c) City or town Florissant 10
(If outside city or town limits, write "RURAL")

(d) Street No. 1150 St. Louis Street 0
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Mathilda Graff

3. (b) If veteran, name war ---

3. (c) Social Security No. ---

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife Frank Graff

6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased Feb. (Month) 8 (Day) 1889 (Year)

8. AGE: Years 57 Months 7 Days 14 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business ---

FATHER
12. Name Henry Temme
13. Birthplace Germany (City, town, or county) (State or foreign country)

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

16. (a) Informant Mr. Frank Graff
(b) Address Florissant, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/46. (Month) (Day) (Year)
(c) Place: burial or cremation Salem Luthern Cem.

18. (a) Signature of funeral director White Funeral Home
(b) Address Ferguson, Missouri

19. (a) 10-8-46 (Date received local registrar) (b) Ruth Allen M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 1 year 1946 hour 5 minute 25 A.M.

21. I hereby certify that I attended the deceased from Death without medical attendance to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Unknown	
Due to 300 a	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy No 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 0

23. Signature Ruth L. Allen M.D. (M. D. or other)
Address 601 Brentwood Blvd. Date signed 10/7/46

(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. L. M. White

Licensed Embalmer No. 3973

P. O. Address Ferguson, 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.