

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29076

State File No.

FILED SEP 4 1947

1003

Registrar's No.

8078

Registration District No.

318

Primary Registration District No.

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Jewish Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 Weeks
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Joseph W. Graves

3. (b) If veteran, name war No. 3. (c) Social Security No. No.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Lulu M. Graves 6. (c) Age of husband or wife if alive 57 years
7. Birth date of deceased Nov. 18th, 1889
(Month) (Day) (Year)

8. AGE: Years 57 Months 9 Days 7 If less than one day hr. min.

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

10. Usual occupation Civil Engineer

11. Industry or business City Of St. Louis

12. Name Chas. R. Graves

13. Birthplace Ill.
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Whitaker
(City, town, or county) (State or foreign country)

15. Birthplace Belleville, Ill.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Lulu M/ Graves

(b) Address 1217 Clara Ave.

17. (a) Burial (b) Date thereof 8/27/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine Cemetery

18. (a) Signature of funeral director Kraeger-Voss, Inc.

(b) Address 3402 N. Kingshighway

19. (a) AUG 26 1947 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1217 Clara Ave
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 25th
year 1947 hour 3 minute 45 A.M.

21. I hereby certify that I attended the deceased from Mar. 3, 1929, to Aug. 25, 1947.
that I last saw him alive on Aug. 24, 1947.
and that death occurred on the date and hour stated above.

Immediate cause of death Sarcoma of Sacrum Duration 3 mos.

Due to _____
Due to _____

Other conditions Pylomyelosis
(include pregnancy within 6 months of death)

Major findings: Of operations _____

Of autopsy Destructive lesion of sacrum
Cystitis & Pylomyelitis

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Hiram Luzzett (M. D. or other) M.D.
Address 3720 Washington Date signed 8/25/47

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

MOTHER FATHER

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.....

J. Allen Davis Jr

Licensed Embalmer No..... *4053*

P. O. Address..... *H. Davis*

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.