

FILED SEP 7 1948

318

STANDARD CERTIFICATE OF DEATH

State File No.

7481

Registration District No.

Primary Registration District No.

1003

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Louis
 (b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Deannoness Hospital
(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

3. (a) PRINT FULL NAME GRAVES, JOSEPH

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

4. Sex MALE 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Dora Fix Graves 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec 14, 1878
(Month) (Day) (Year)

8. AGE: Years 69 Months 8 Days 12 If less than one day _____ hr. _____ min.

9. Birthplace brookport N. Y.
(City, town, or county) (State or foreign country)

10. Usual occupation Grocer

11. Industry or business _____

12. Name Clark Virgil Graves

18. Birthplace Vienna N. Y.
(City, town, or county) (State or foreign country)

14. Maiden name Eleanor Hall

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

16. (a) Informant Clark V. Graves

(b) Address 3120 North Taylor

17. (a) Burial (b) Date thereof 8/27/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peters Cemetery

18. (a) Signature of funeral director Stroet - Carroll

(b) Address 4600 Natural Bridge Ave

19. (a) AUG 26 1948 J. F. Bredack
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County FOO
 (c) City or town St. Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 3120 North Taylor Ave
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUG day 26
 year 1948 hour 5 minute 30 A.M.

21. I hereby certify that I attended the deceased from FEB
 1948 to AUG 26, 1948

that I last saw him alive on AUG 25, 1948
 and that death occurred on the date and hour stated above.

Immediate cause of death CEREBRAL HEMORRHAGE, RT. E. HEMIPLEGIA

Due to HYPERTENSION, ESSENTIAL

Due to NEPHROSCLEROSIS

Other conditions AS ABOVE
(Include pregnancy within 6 months of death)

Major findings: Of operations _____

Of autopsy AS ABOVE

22. If death was due to external cause, 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 Robert E. Cochran, M.D.
 Address 3720 WASHINGTON Date signed 8.26.48

Duration
12 hrs.
5 yrs.
22
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

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

Bent Hoffman

Licensed Embalmer No. *4366*

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, above space should be left blank.