

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9669

State File No.

FILED APR 14 1949

BIRTH NO. _____ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 6058 Registrar's No. 69

1. PLACE OF DEATH a. COUNTY <u>St Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St Charles</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Charles Co. Rt #2</u>	c. LENGTH OF STAY (in this place) <u>24 hrs</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Charles Mo</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Rt #2 St Charles Mo</u>		d. STREET ADDRESS (If rural, give location) <u>1612 No 3rd</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Louis</u>	b. (Middle)	c. (Last) <u>Gravemann</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>March 25 1949</u>
--	-------------------------	-------------	----------------------------	--

5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Nov 2-1879</u>	9. AGE (In years last birthday) <u>70</u>	IF UNDER 1 YEAR Months Days Hours Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	11. BIRTHPLACE (State or foreign country) <u>New Melle Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
--------------------	------------------------------	---	---------------------------------------	--	---	--	--	--	--

13a. FATHER'S NAME <u>Charles Gravemann</u>	13b. MOTHER'S MAIDEN NAME <u>Margaret Brown</u>	14. NAME OF HUSBAND OR WIFE
--	--	-----------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Charles F. Gravemann</u>	ADDRESS <u>O'Fallon Mo</u>
---	--	--	-------------------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic Glomerular Nephritis</u> DUE TO (c) <u>Chronic myocarditis 4 1/2 21</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>secondary aneurysm</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
------------------------	----------------------------------	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
--	--	----------------------------

22. I hereby certify that I attended the deceased from May 1946, to Mar 19, 1949, that I last saw the deceased alive on Mar 19, 1949 and that death occurred at 4:15 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Dr. F. R. Harrington, D.O.</u>	23b. ADDRESS <u>St. Charles Mo</u>	23c. DATE SIGNED <u>3-28-49</u>
---	---------------------------------------	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>March 28 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St John's</u>	24d. LOCATION (City, town, or county) (State) <u>St Charles Mo</u>
--	-----------------------------------	--	---

DATE REC'D BY LOCAL REG. <u>4/17/49</u>	REGISTRAR'S SIGNATURE <u>Francis Hammett</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Thaddeus Paul</u>	ADDRESS <u>St Charles Mo</u>
--	---	--	---------------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

Date Filed APR 12 1945

District File Number _____

District Health Officer No. 9

RECEIVED

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Arthur O. Bone

Signed _____
Student Embalmer

Licensed Embalmer No. 3155

P. O. Address St Charles 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.