

FILED NOV 17 1950  
#116419

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 38550  
Registrar's No. 9454

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		c. LENGTH OF STAY (In this place) 2 2/3	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Mo ST. Louis 2279		d. STREET ADDRESS (If rural, give location) #1. 1309 So. 13th	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital		4. DATE OF DEATH (Month) (Day) (Year) November 5th, 1950	
3. NAME OF DECEASED (Type or Print) a. (First) AUGUST b. (Middle) GRAFF c. (Last)		9. AGE (In years) (If under 1 year: Months) (If under 12 hrs.: Hours) (Min.) 86	
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Div 3	8. DATE OF BIRTH OCT. 28-1864
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATCH MAN		10b. KIND OF BUSINESS OR INDUSTRY CITY HALL	11. BIRTHPLACE (State or foreign country) ST. Louis Mo
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME EMIL GRAFF	
13b. MOTHER'S MAIDEN NAME ANTONIA GOODWALL		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME		ADDRESS	

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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) <i>Posterior Myocardial Infarction</i>		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>arterio sclerosis of coronary artery</i>		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? H 201

22. I hereby certify that I attended the deceased from 11/4/50 10:00 PM to 11/5/50 11:00 PM, 1950, that I last saw the deceased alive on 11/5/50, 1950, and that death occurred at 11:00 PM, from the causes and on the date stated above.

23a. SIGNATURE <i>Joseph J. ...</i>	(Degree or title)	23b. ADDRESS 1515 Lafayette Ave.,	23c. DATE SIGNED 11/6/50
24a. BURIAL CREMATION REMOVAL (Specify)	24b. DATE 11-7-50	24c. NAME OF CEMETERY OR CREMATORY OLD PICKERS	24d. LOCATION (City, town, or county) (State) ST. Louis Mo
DATE REC'D BY LOCAL REG. NOV 7 1950	REGISTRAR'S SIGNATURE <i>J. C. ...</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>J. ...</i> ADDRESS 3125 Lafayette	

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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.....

.....  
working under my personal supervision.

Student Embalmer No.....

Signed.....  
Student Embalmer

Signed

*Joseph B. Walker*

Licensed Embalmer No. *4014*

P. O. Address *.....*

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.