

FILED APR 20 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

14133  
State File No. 3312  
Registrar's No. 3312

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS	
c. LENGTH OF STAY (In this place)		2199	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 3745 Lindell Blvd		STREET ADDRESS (If rural, give location) 3745 Lindell Blvd	

3. NAME OF DECEASED (Type or Print) a. (First) FREDRICK FREDERICK b. (Middle) H. H. c. (Last) GRAVES. GRAVES	4. DATE OF DEATH (Month) (Day) (Year) 4 6 51
5. SEX Male 0	6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 9	8. DATE OF BIRTH Oct. 2, 1886
9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired: (un)	10b. KIND OF BUSINESS OR INDUSTRY (not stated)
11. BIRTHPLACE (State or foreign country) Lynn, Mass.	12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Samuel Graves.	13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE Lillian Harris Graves.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) yes; unknown	17. INFORMANT'S SIGNATURE OR NAME Mrs. Lillian H. Graves. St. Louis, Mo.

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CORONARY HEART DISEASE ANTECEDENT CAUSES DUE TO (b) DIABETES MELLITUS Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 yrs. 1 yr.
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? H201

22. I hereby certify that I attended the deceased from Jan., 1951, to APRIL, 1951, that I last saw the deceased alive on APRIL 6, 1951, and that death occurred at 3:35 P.M., from the causes and on the date stated above.

23a. SIGNATURE Robert M. Launch M.D. (Degree or title)	23b. ADDRESS St Paul Hospital	23c. DATE SIGNED 4-6-51
24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	24b. DATE 4-10-1951	24c. NAME OF CEMETERY OR CREMATORY Oak Grove Crematory
24d. LOCATION (City, town, or county) (State) St. Louis Co, Mo.	25. FUNERAL DIRECTOR'S SIGNATURE C.R. Lupton & Sons; 7233 Delmar Blvd.	
DATE REC'D BY LOCAL REG APR 9 1951	REGISTRAR'S SIGNATURE J B Laster	ADDRESS

WRITE PLAINLY—USING UNFAADING 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.....

.....  
working under my personal supervision.

Student Embalmer No.....

Signed Melvin L. Kemper

Signed.....  
Student Embalmer

Licensed Embalmer No. 405-2

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, fact should be so stated above.