

FILED NOV 24 1951

THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39057**
Registrar's No. **9815**

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) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		STREET ADDRESS (If rural, give location) 1318 N Newstead	

3. NAME OF DECEASED (Type or Print) a. (First) Batie b. (Middle) c. (Last) Graves		4. DATE OF DEATH (Month) (Day) (Year) Nov. 5 1951	
5. SEX Female 3	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH March 8, 1894
9. AGE (In years last birthday) 56		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil	11. BIRTHPLACE (State or foreign country) Mississippi
12. CITIZEN OF WHAT COUNTRY? U S A			

13a. FATHER'S NAME Sam Gray	13b. MOTHER'S MAIDEN NAME Addine Robinson	14. NAME OF HUSBAND OR WIFE None
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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Undet.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma with generalized Abdominal		
	ANTECEDENT CAUSES Metastasis (site undetermined) DUE TO (b) Undetermined DUE TO (c) X None XXX		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None			

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) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR 1998

22. I hereby certify that I attended the deceased from **8-21**, 19 **51**, to **11-5**, 19 **51**, that I last saw the deceased alive on **11-5**, 19 **51**, and that death occurred at **11:00 p. m.**, from the causes and on the date stated above.

22a. SIGNATURE (Degree or title) Clarence M. Turner, D. O.	22b. ADDRESS 2601 N Whittier St.	22c. DATE SIGNED 11-6-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 11-6-51	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Montgomery City, Mo.
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DATE RECD BY LOCAL REG. NOV 6 1951	REGISTRAR'S SIGNATURE Earl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe 4700 Washington
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WRITE PLAINLY—USING 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.....

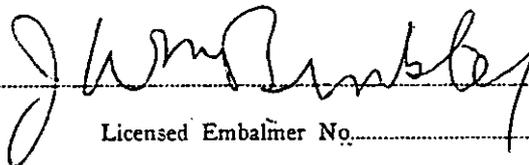
..... Student Embalmer No.

working under my personal supervision.

Student

Student Embalmer

Signed



Licensed Embalmer No. 3657

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.