

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

2826

FILED FEB 4 1954 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 State File No. 2826 Registrar's No. 0866

<b>1. PLACE OF DEATH</b> a. COUNTY		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY 2027	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	c. LENGTH OF STAY (In this place)	e. CITY OR TOWN St. Louis	d. Is residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4945 Blow St.		e. STREET ADDRESS (If rural, give location) 4945 Blow St.	

<b>3. NAME OF DECEASED</b> (Type or Print)	a. (First) MARY	b. (Middle)	c. (Last) GRAF	<b>4. DATE OF DEATH</b> (Month) (Day) (Year) Jan. 26 1954
-----------------------------------------------	-----------------	-------------	----------------	-----------------------------------------------------------------

<b>5. SEX</b> Female	<b>6. COLOR OR RACE</b> White	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) Widow	<b>8. DATE OF BIRTH</b> March 20, 1882	<b>9. AGE</b> (In years last birthday) 71	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.
-------------------------	----------------------------------	------------------------------------------------------------------------	-------------------------------------------	-------------------------------------------	---------------------------------------	---------------------------------------

<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Housework	<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	<b>11. BIRTHPLACE</b> (City and State or Foreign Country) St. Louis Co. Mo. 0	<b>12. CITIZEN OF WHAT COUNTRY?</b>
-----------------------------------------------------------------------------------------------------------------	------------------------------------------	----------------------------------------------------------------------------------	-------------------------------------

<b>13a. FATHER'S NAME</b> Leopold Ritter	<b>13b. MOTHER'S MAIDEN NAME</b> Magdalene Reberd	<b>14. NAME OF HUSBAND OR WIFE</b> Late Edward Graf
---------------------------------------------	------------------------------------------------------	--------------------------------------------------------

<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) No	<b>16. SOCIAL SECURITY NO.</b>	<b>17. INFORMANT'S SIGNATURE OR NAME</b> Walter Graf	<b>ADDRESS</b> 6039 Hancock Ave.
-----------------------------------------------------------------------------------------------------------------------	--------------------------------	---------------------------------------------------------	-------------------------------------

<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	<b>MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> 3 years
	<b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <u>Hypertensive Heart Disease</u>		
	<b>ANTECEDENT CAUSES</b> Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b)  DUE TO (c)		
<b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death.			

<b>19a. DATE OF OPERATION</b> None	<b>19b. MAJOR FINDINGS OF OPERATION</b>	<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
---------------------------------------	-----------------------------------------	--------------------------------------------------------------------------------------------

<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify) No	<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b> 443X
-------------------------------------------------------	-------------------------------------------------------------------------------------------------	----------------------------------------------------------------

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

**22. I hereby certify that I attended the deceased from May 23, 1951, to January 26, 1954, that I last saw the deceased alive on January 24, 1954, and that death occurred at 10:30 P.M., from the causes and on the date stated above.**

<b>23a. SIGNATURE</b> Bernard T. Koon	(Degree or title) M.D.	<b>23b. ADDRESS</b> 4755 Thompson Road St. Louis, Mo.	<b>23c. DATE SIGNED</b> 1/27/54
------------------------------------------	---------------------------	-------------------------------------------------------------	------------------------------------

<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) Removal	<b>24b. DATE</b> Jan. 29, 1954	<b>24c. NAME OF CEMETERY OR CREMATORY</b> Sunset Burial Park	<b>24d. LOCATION</b> (City, town, or county) (State) St. Louis Co. Mo.
-------------------------------------------------------------	-----------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------------

<b>DATE REC'D BY LOCAL REG.</b> JAN 27 1954	<b>REGISTRAR'S SIGNATURE</b> J. Carl Smith M.D.	<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> Kriegshauser	<b>ADDRESS</b> 4228 S. Kingshighway Bl.
------------------------------------------------	----------------------------------------------------	---------------------------------------------------------	--------------------------------------------

(Licensed Embalmer's Statement on Reverse Side)

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.....  
Signature of Student Embalmer

Signed *William B. White*.....

Licensed Embalmer No. *429*

P. O. Address *4228 S. King*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.