

FILED JAN 18 1955

STANDARD CERTIFICATE OF DEATH

State File No. 2819

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. #18

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Illinois b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Harrisburg 81208	
c. LENGTH OF STAY (In this place) 24 Days		d. STREET ADDRESS (If rural, give location) unknown	
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnes Hospital O			

3. NAME OF DECEASED (Type or Print) Bessie			a. (First)		b. (Middle) NNN		c. (Last) McGraner		4. DATE OF DEATH January 1, 1955		
5. SEX female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH 1-15-1888		9. AGE (In years last birthday) 66		IF UNDER 1 YEAR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (City and State or Foreign Country) Saline County, Ill. /			12. CITIZEN OF WHAT COUNTRY? USA		

13a. FATHER'S NAME Bill Yarber		13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE George McGraner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Helen Riedes, Christopher, Ill	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Cervix				INTERVAL BETWEEN ONSET AND DEATH 18 Months	
* This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Acute Pyelonephritis				2 weeks	

19a. DATE OF OPERATION 12/16/54		19b. MAJOR FINDINGS OF OPERATION Carcinoma of Cervix		20. AUTOPSY? YES <input checked="" 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 12/7, 1954, to 1/1, 1955, that I last saw the deceased alive on 1/1, 1955, and that death occurred at 1:50 A m., from the causes and on the date stated above.

23a. SIGNATURE HR Pradey		(Degree or title) O M. D.		23b. ADDRESS Barnes Hospital		23c. DATE SIGNED 1/1/55	
24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 1-1-55		24c. NAME OF CEMETERY OR CREMATORY Harrisburg, Ill.		24d. LOCATION (City, town, or county) (State)	

DATE REC'D BY LOCAL REG. 1955 JAN 3 1955		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Harrisburg F.H., Harrisburg, Ill.	
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mjs (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
Student Embalmer

Signed _____

J. Allen Dwyer
4063

Licensed Embalmer No. _____

P. O. Address _____
St. L.

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.