

FILED MAR 21 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9241**

BIRTH NO. _____		REG. DIST. NO. 306		PRIMARY REG. DIST. NO. 6048		Registrar's No. 66			
1. PLACE OF DEATH a. COUNTY St. Charles				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Charles					
b. CITY OR TOWN O'Fallon		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN O'Fallon		0920			
d. FULL NAME OF HOSPITAL OR INSTITUTION _____				d. STREET ADDRESS (If rural, give location) _____					
3. NAME OF DECEASED (Type or Print) a. (First) Charles			b. (Middle) F. Graveman			c. (Last) _____			
5. SEX male			6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, married		8. DATE OF BIRTH Feb. 11 1871		
9. AGE (In years last birthday) 84			IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 HRS. Hours _____ Min. _____		4. DATE OF DEATH March 15 1955		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired			10b. KIND OF BUSINESS OR INDUSTRY farming		11. BIRTHPLACE (State or foreign country) St. Charles Co. Mo. O			12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Charles Graveman			13b. MOTHER'S MAIDEN NAME Brown			14. NAME OF HUSBAND OR WIFE Matilda Graveman			
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 Matilda Graveman			ADDRESS O'Fallon 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, asthenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Branchio Streptococcal Virus Infection					INTERVAL BETWEEN ONSET AND DEATH 10 days 10 day		
		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.							
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____					20. AUTOPSY? 491X YES <input 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 3-1 , 19 55 to 3-16 , 19 55 , that I last saw the deceased alive on 3-4 , 19 55 , and that death occurred at 9:15 m., from the causes and on the date stated above.									
23a. SIGNATURE Charles H. Tree M.D. (Degree or title)				23b. ADDRESS Dentonville Mo		23c. DATE SIGNED 3-16-55			
24a. BURIAL, CREMATION, REMAINS (Specify) Burial		24b. DATE March 18 1955		24c. NAME OF CEMETERY OR CREMATORY Immanuel Luthern		24d. LOCATION (City, town, or county) St. Charles (State) Mo			
DATE REC'D BY LOCAL REG. 3-16 '55		REGISTRAR'S SIGNATURE E.A. Keishly 280-0		25. FUNERAL DIRECTOR'S SIGNATURE E.A. Keishly		ADDRESS O'Fallon Mo.			

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

E. Keithly

Licensed Embalmer No. *822*

P. O. Address *O'Fallon 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.