

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

10319

STATE FILE NUMBER  
2928

FILED APR 15 1957

Registration District No. **318** Primary Registration District No. **1003**

Registrar's No. **2928**

Health,  
Welfare  
Public  
Service

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>ILLINOIS</b> b. COUNTY <b>MADISON</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>GRANITE CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>CHRISTIAN HOSP.</b>		Length of stay in lb <b>7 DAYS</b>	d. STREET ADDRESS (If outside, give location) <b>2508 PROPE S ST.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>S.</b> Last <b>GRAHAM</b>			4. DATE OF DEATH Month <b>3</b> Day <b>25</b> Year <b>1957</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-30-1888</b>	9. AGE (In years last birthday) <b>68</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PIG MACH. OPERATOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>G. C. STEEL CO.</b>	11. BIRTHPLACE (City and state or country) <b>DUNLAP, TENNESSEE</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>ERIN GRAHAM</b>			14. MOTHER'S MAIDEN NAME <b>ANN MINTON</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>333-03-7577</b>	17. INFORMANT <b>Lela Graham</b> Address <b>2508 PROPE GRANITE CITY</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis Mesentery</b> <b>Uremia &amp; Abdominal hemorrhage</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Uremia &amp; Abdominal hemorrhage</b> DUE TO (c) <b>—</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Anthracosis Advanced Lungs</b>					INTERVAL BETWEEN ONSET AND DEATH <b>?</b>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY STATE
21. I attended the deceased from <b>2-18-57</b> to <b>3-25-57</b> and last saw <sup>her</sup> him alive on <b>3-25-57</b> Death occurred at <b>11254</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Joe E. Cadioppo</b>			22b. ADDRESS <b>3861 St. Louis Ave</b>		22c. DATE SIGNED <b>3/26/57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>3-25-1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SUNSET HILL</b>	23d. LOCATION (City, town, or county) (State) <b>EDWARDSVILLE, ILLINOIS</b>	
24. FUNERAL DIRECTOR <b>Frank Moore</b>		ADDRESS <b>Grant Ct. Lee</b>	25. DATE RECD. BY LOCAL REG. <b>MAR 26 '57</b>	26. REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</b>	

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 *Charles E. Mercer*

Licensed Embalmer No. *298*

P. O. Address *Essex City*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.