

Health, Welfare
Public
Service

300
-56

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29499

STATE FILE NUMBER

FILED AUG 26 1957

318

1003

7264

Registration District No. Primary Registration District No. Registrar's No.

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, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4322 Gibson			Length of stay in ib		18 STREET ADDRESS 4322 Gibson		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Philip Graul				4. DATE OF DEATH Month Day Year Aug 3 1957					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 22 1879		9. AGE (In years last birthday) 78	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Blairsville Ind.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John Graul				14. MOTHER'S MAIDEN NAME Mary Adams					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Wife Address Mary Graul 4322 Gibson				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia DUE TO (b) Atevacarium of Prostate DUE TO (c) 177XF CONDITIONS (if any which gave rise to above cause (a), showing the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture intertrochanteric, left femur								INTERVAL BETWEEN ONSET AND DEATH 3 Days 4 yrs	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input checked="" 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.) Walking from Bathroom holding arm of wife, being in 20c. TIME OF INJURY. Hour Month, Day, Year 10 2 13 57 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) 18 HOME 4322 GIBSON 20f. CITY, TOWN, OR LOCATION ST. LOUIS MO 20g. COUNTY ST. LOUIS MO 20h. STATE MO							
21. I attended the deceased from 1952 to Aug 1957 and last saw him alive on 8-2-57 Death occurred at 5:45 A m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE John J. Orshy MD				22b. ADDRESS 5203 Chippewa				22c. DATE SIGNED 8/3/57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Aug 5 57		23c. NAME OF CEMETERY OR CREMATORY Lake Charles		23d. LOCATION (City, town, or county) (State) St. Louis Cty Mo			
24. FUNERAL DIRECTOR E. J. Schnur 3125 Lafayette				25. DATE RECD. BY LOCAL REG. AUG 5 57		26. REGISTRAR'S SIGNATURE J. Carl Smith MD			

(Licensed Embolmer's Statement on Reverse Side)

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 *Joseph Williams*

Licensed Embalmer No. *418*

P. O. Address *3125 Poplar*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.