

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33375
STATE FILE NUMBER
8751

FILED SEP 26 1957 Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. LOUIS</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWNSHIP <u>ST. LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>VET. ADM. HOSPITAL</u>			Length of stay in 1b <u>25 DAYS</u>		d. STREET ADDRESS <u>3117 N TAYLOR AVE.</u>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>DOSSIEBIE</u> Last <u>GRAPE</u>				4. DATE OF DEATH Month <u>9</u> Day <u>14</u> Year <u>57</u>									
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-7-16</u>		9. AGE (In years last birthday) <u>42</u>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>LACLEDE CHRISTY CO.</u>		11. BIRTHPLACE (City and state or country) <u>WARE, MISSISSIPPI</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>JAMES GRAPE</u>						14. MOTHER'S MAIDEN NAME <u>HENRIETTA TURNIPSEED</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WW 2</u>				16. SOCIAL SECURITY NO. <u>492-07-4159</u>		17. INFORMANT Address <u>VA HOSP. RECORDS 915 N GRAND ST LOUIS MO.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA * RENAL FAILURE</u>										INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										DUE TO (b) <u>MALIGNANT HYPERTENSION, UNKNOWN CAUSE.</u>			
										DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
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 <u>8-20-57</u> to <u>9-14-57</u> and last saw <u>him</u> alive on <u>9-14-57</u> Death occurred at <u>9:20 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>A.E. Carl</u> (Degree or title)						22b. ADDRESS <u>M. D. VAH. ST. LOUIS, MO.</u>				22c. DATE SIGNED <u>9-14-57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>9-20-57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>				23d. LOCATION (City, town, or county) (State) <u>Jefferson Barracks Mo.</u>					
24. FUNERAL DIRECTOR <u>J. McClendon 4535 Washington Blvd.</u>						25. DATE RECD. BY LOCAL REG. <u>SEP 18 57</u>		26. REGISTRAR'S SIGNATURE <u>J. Carl Smith MD</u>					

(Licensed Embalmer's Statement on Reverse Side)

Use only black ink or ribbon typewrite if possible. 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

MEDICAL CERTIFICATION

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 *John K. Cunningham*
Licensed Embalmer No. *41*

P. O. Address *2405 M*

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.