

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

37072

FILED OCT 31 1957

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 330

1. PLACE OF DEATH a. COUNTY <b>St. Francois</b>			2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Francois</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <b>Bonne Terre</b> TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Bonne Terre</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		Length of stay in 1b <b>unk.</b>	d. STREET ADDRESS <b>104 Brand Pl.</b> (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>WALTER HERMAN GRAESER</b>			4. DATE OF DEATH <b>Oct. 15, 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>May 26, 1890</b>	9. AGE (In years last birthday) <b>67</b>	IF UNDER 1 YEAR Months <b>4</b> Days <b>19</b> Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Acct. Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>August. Graeser</b>			14. MOTHER'S MAIDEN NAME <b>Emma Jahn</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>490 03 6885</b>	17. INFORMANT <b>A. Elenora Graeser Bonne Terre, Mo</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>Myocardial infarction</b>					INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic bronchial pulmonary disease.</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.) <b>4201</b>		
20c. TIME OF INJURY Hour <b></b> Month <b></b> Day <b></b> Year <b></b> a. m. <b></b> p. m. <b></b>					
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>10-4-53</b> to <b>10-15-57</b> and last saw <sup>him</sup> <del>her</del> alive on <b>10-15-57</b> Death occurred at <b>11:50</b> a m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Kate M. Miller MD</i> (Deceased or title)			22b. ADDRESS <b>Bonne Terre, Mo.</b>		22c. DATE SIGNED <b>10-18-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Oct. 18-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Paul &amp; Peter Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>	
24. FUNERAL DIRECTOR <b>BOYER-BENHAM FH BONNE TERRE, MO.</b>		ADDRESS	25. DATE RECD. BY LOCAL REG. <b>Oct. 18, 1957</b>	26. REGISTRAR'S SIGNATURE <i>Ether Rudloff</i>	

(Licensed Embalmer's Statement on Reverse Side)

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 causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

-890

OCT 31 1957

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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 *B. T. Royer*.....

Licensed Embalmer No. *76*

P. O. Address *Asheley*

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.