

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JAN 30 1958

2963  
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **495**

300  
7-57

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY		
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>St. Louis</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>5441 Euclid Ave.</b>		Length of stay in lb <b>40 yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>5441 Euclid Ave.</b>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>HENRY</b> First <b>E.</b> Middle <b>GRAEF</b> Last			4. DATE OF DEATH Month <b>Jan.</b> Day <b>12,</b> Year <b>1958</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>June 1, 1885</b>		9. AGE (In years last birthday) <b>72</b> IF UNDER 1 YEAR Months <b>7</b> Days <b>11</b> IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>florist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bellevue Cemetery</b>		11. BIRTHPLACE (City and state or country) <b>Blue Point, Ill.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13a. FATHER'S NAME <b>Daniel Graef</b>		
13b. MOTHER'S MAIDEN NAME <b>Bertha Kurtz</b>			14. NAME OF HUSBAND OR WIFE <b>Catherine Graef</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>489-03-0491</b>		17. INFORMANT Address <b>Catherine Graef 5441 Euclid Ave.</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>Common Tuberculosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic Heart Disease</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)					INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>4 yrs</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>420.0.</b>			
20c. TIME OF INJURY Hour <b></b> a.m. <b></b> p.m. <b></b>		20d. INJURY OCCURRED WHILE AT <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 Death occurred at <b>Jan 5-58</b> to <b>Jan 11th</b> and last saw him alive on <b>Jan 10th 58</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Francis Mueller MD</b> (Degree or title)		22b. ADDRESS <b>4114 W. Howard</b>		22c. DATE SIGNED <b>1/14/58</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>Jan 16 1958</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	
23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>		24. FUNERAL DIRECTOR <b>Bromschwig and Son/W Florissant</b>		25. DATE RECD. BY LOCAL REG. <b>JAN 15 '58</b>	
26. REGISTRAR'S SIGNATURE <b>J. Carl Smith, M.D.</b> <b>S.P.</b>					

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be stated. All diseases in Part I must be causally related.

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 *Stanley G. Simpson* .....  
Licensed Embalmer No. *4193* .....  
P. O. Address *H. L.* .....

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.