

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-015842  
STATE FILE NUMBER  
4829

FILED MAY 12 1958

Registration District No. 318 Primary Registration District No. 1003

Registrar's No. 4829

300  
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		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	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 25 St. Louis City Hosp		Length of stay in lb 3 Days 29		d. STREET ADDRESS (If outside, give location) 5410 Finkman	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					

3. NAME OF DECEASED (Type or print) First Middle Last August C. Graber			4. DATE OF DEATH Month Day Year 5 3 58		
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5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 17, 1890	9. AGE in years (birth day) 67	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FORGMAN	10b. KIND OF BUSINESS OR INDUSTRY VALLEY ELEC.	11. BIRTHPLACE (City and state or country) Edwardsville ILL.	12. CITIZEN OF WHAT COUNTRY? U.S.A
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13a. FATHER'S NAME CARL AUGUST GRABER	13b. MOTHER'S MAIDEN NAME UNKNOWN MARY VOGEL	14. NAME OF HUSBAND OR WIFE Edna GRABER
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES DWAT	16. SOCIAL SECURITY NO. 497-01-6094	17. INFORMANT Edna GRABER, 5410 FINKMAN.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	332x
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 type="checkbox"/> NO <input checked="" 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
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21. I attended the deceased from 4/30/58 to 5/3/58 and last saw her alive on 5/3/58  
Death occurred at 1:35 PM on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE W. Leightner MD	(Degree or title)	22b. ADDRESS 1515 LAFAYETTE AVE	22c. DATE SIGNED 5/5/58
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23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 5/6/58	23c. NAME OF CEMETERY OR CREMATORY NATIONAL CEM.	23d. LOCATION (City, town, or county) (State) JEFF. BRKS. MO
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24. FUNERAL DIRECTOR FENNER UNCL. 1420 Michigan	ADDRESS	25. DATE RECD. BY LOCAL REG. MAY 6 '58	26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. S.P.
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Corrected by Asst. July 8, 1958 B.W.

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.

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 *W. G. Peterson* .....

Licensed Embalmer No. *3767*  
P. O. Address *2420 Michigan*

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.