

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-037520
STATE FILE NUMBER

FILED NOV 13 1958 Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 403

1. PLACE OF DEATH a. COUNTY <u>ST. FRANCIS</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 TOWN <u>BONNE TERRE</u>		c. CITY OR TOWN <u>ST. LOUIS 2009</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BONNE TERRE HOSP.</u>		d. STREET ADDRESS (If outside, give location)	
Length of stay in lb <u>2 da.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>DONALD LEE MCGRAW</u>			4. DATE OF DEATH Month Day Year <u>OCT. 29, 1958</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</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>MAY 28, 1930</u>		9. AGE (In years last birthday) <u>29</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>McDONALD G. KRAFT</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (City and state or country) <u>Esthly MO</u>	
10c. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>CHARLES MCGRAW</u>		13b. MOTHER'S MAIDEN NAME <u>ESSIE FRANKLIN</u>	
13c. NAME OF HUSBAND OR WIFE <u>ALBERTA MCGRAW</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>490-25-7816</u>	
17. INFORMANT <u>Charles McGraw Farmington 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>Malignant Brain tumor</u>		INTERVAL BETWEEN ONSET AND DEATH <u>18 mo</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>1930</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in PART I or PART II of item 18.) <u>ITEM 4 CORRECTED</u>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		BY AFFIDAVIT OF <u>Funeral Director</u> <u>1-3-59</u>	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <u>Farmington</u>		COUNTY STATE	

21. I attended the deceased from <u>10-26-58</u> , to <u>10-29-58</u> and last saw him alive on <u>10-29-58</u> Death occurred at <u>3:30 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>C.E. Carleton M.D.</u>	(Degree or title) <u>D</u>	22b. ADDRESS <u>Farmington, Mo</u>	22c. DATE SIGNED <u>11-1-58</u>

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>NOV. 1, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hill Top Memorial</u>	23d. LOCATION (City, town, or county) (State) <u>Near Farmington, Mo</u>
24. FUNERAL DIRECTOR <u>Raymond Caldwell</u>		ADDRESS <u>Flat 1000</u>	25. DATE RECD. BY LOCAL REG. <u>Nov 4, 1958</u>
26. REGISTRAR'S SIGNATURE <u>Gertner Rueloff</u>			

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

MS FEB 3 1958

NOV 14 1958

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 *R. Caldwell*

Licensed Embalmer No. *2531*

P. O. Address *Flat 8 West*

Noté: 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.