

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-037801

STATE FILE NUMBER

10266

FILED NOV 10 1958

Registration District No.

318

Primary Registration District No.

1009

Registration District No.

300
1-57

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

| | | | | | |
|--|---------------------------|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri | | 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 | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET (If outside, give location) ADDRESS 6253 Marmaduke Ave | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 6253 Marmaduke Ave | | Length of stay in lb 2 Mo. | | 01 | |
| 3. NAME OF DECEASED (Type or print) First Middle Last James H. Graham | | | 4. DATE OF DEATH Month Day Year October 27 1958 | | |
| 5. SEX Male <input checked="" type="checkbox"/> | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 22, 1876 | 9. AGE (In years last birthday) 81 | IF UNDER 1 YEAR Months Days |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant | | 10b. KIND OF BUSINESS OR INDUSTRY Cullman Co. Ala. | 11. BIRTHPLACE (City and state or country) Athens, Alabama | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13a. FATHER'S NAME Luther Graham | | 13b. MOTHER'S MAIDEN NAME Betty Baker | | 14. NAME OF HUSBAND OR WIFE Lily Keyes Graham | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address St. Louis, Mo. Rev. O. T. Foster, 6253 Marmaduke Ave. | |
| 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>Cerebral Vascular Accident</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH 48 hrs. |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis, Generalized</u> | | | | | 10-15 yrs |
| DUE TO (c) <u>331x</u> | | | | | |
| 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 <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>October 1</u> to <u>October 26</u> and last saw her/him alive on <u>26 October</u> Death occurred at <u>2:15 A. M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Rosemary R. Jarkin, M.D.</u> | | | 22b. ADDRESS <u>2730 Watson Pl.</u> | | 22c. DATE SIGNED <u>10-27-58</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 23b. DATE <u>Oct. 27, 1958</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Athens, Alabama</u> | | 23d. LOCATION (City, town, or county) (State) |
| 24. HOPPELSTYER COLONIAL MORTUARY <u>6464 CHIPPEWA STREET, ST. LOUIS, MO.</u> | | | 25. DATE RECD. BY LOCAL REG. <u>OCT 27 '58</u> | | 26. REGISTRAR'S SIGNATURE <u>J. Carl Smith, M.D.</u> J. P. |

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 *Bill C. Branson*

Licensed Embalmer No. *4364*

P. O. Address *St. Louis Mo.*

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.