

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027550

FILED VS AUG 3 1959
 Registration District No. 317 Primary Registration District No. 546 Registrar's No. 2027 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis County</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Francois</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Overland 14, Mo.</u>		c. CITY OR TOWN <u>Desloge</u>	
Length of stay in 1b <u>overnight</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location) <u>highway 32</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Lawrence</u> Last <u>Graf</u>			4. DATE OF DEATH Month <u>July</u> Day <u>26</u> Year <u>1959</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>Oct. 3, 1905</u>	9. AGE (last birthday) <u>53</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>lead mining</u>		11. BIRTHPLACE (City and state or country) <u>Ste. Genevieve County, Mo. U.S.</u>		12. CITIZEN OF WHAT COUNTRY
13a. FATHER'S NAME <u>Frank Graf</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Gegg</u>		14. NAME OF HUSBAND OR WIFE <u>Alma Marie Womack</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>493-03-9195</u>		17. INFORMANT <u>wife</u> Address <u>Desloge, Mo.</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<u>Ruptured ventricular aneurysm</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arterial myocardial degeneration</u>	
	DUE TO (c) <u>Arterio sclerosis.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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 _____ g.m. _____ p.m. _____	Month, Day, Year		
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 <u>April 1 - 1956</u> to <u>July 26 59</u> and last saw ^{her} him <u>live</u> on <u>May 16 - 59</u> Death occurred at <u>a</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) <u>C H Appleberry MD</u>		22b. ADDRESS <u>Reveries MO</u>		22c. DATE SIGNED <u>7-27-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>July 29, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parkview CEM.</u>	23d. LOCATION (City, town, or county) (State) <u>St. Francois Mo.</u>	
24. FUNERAL DIRECTOR <u>Alvin W. Hood</u>		ADDRESS <u>303 Crane St. Flat River Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>7-30-59</u>
26. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

3935 8 510

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Abner W. Hood

Licensed Embalmer No. 2780

P. O. Address Mar R

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.