

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-031099**

**FILED VS AUG 31 1959**

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2283

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Normandy</b>		Length of stay in 1b <b>HRS.</b>		c. CITY OR TOWN <b>Jennings</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>Normandy Osteopathic</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>8720 Akins Drive</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>J.</b> Last <b>McGRAW</b>				4. DATE OF DEATH Month <b>August</b> Day <b>22</b> Year <b>1959</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>Oct 1, 1901</b>	9. AGE (last birthday) <b>57</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>auto mechanic</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>William McGraw</b>			13b. MOTHER'S MAIDEN NAME <b>Elizabeth Weston</b>		14. NAME OF HUSBAND OR WIFE <b>Mildred McGraw</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>498-34-6596</b>	17. INFORMANT Address <b>Mildred McGraw 8720 Akins DR.</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>Metabolic encephalopathy</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>cerebral hemorrhage</b> DUE TO (c) <b>Hypertensive heart disease atherosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2-3 minute</b> <b>2-3 minute</b> <b>18 years</b>	
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 a.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 <b>5-2-57</b> to <b>date</b> and last saw him alive on <b>8-17-59</b> Death occurred at <b>9:15 AM</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>George D. Wohlhoffer D.O.</b>				22b. ADDRESS <b>6401 W. Florissant</b>		22c. DATE SIGNED <b>8-22-59</b>	
23a. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23b. DATE <b>Aug 25 1959</b>		23c. LOCATION (City, town, or county) <b>St. Louis, Missouri</b>		23d. (State)	
24. FUNERAL DIRECTOR <b>Bromschwig and Son</b>			ADDRESS <b>4746</b>	25. DATE RECD. BY LOCAL REG. <b>8-24-59</b>	26. REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SA JUL 19 1961

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Elmer R. Sadler

Licensed Embalmer No. 407

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.