

**FEDERAL BUREAU OF INVESTIGATION - DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-041888**

**FILED VS NOV 20 1959**

**210416** STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

<b>1. PLACE OF DEATH</b> a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST LOUIS, MO.</b> Length of stay in 1b _____		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> COUNTY <b>JEFFERSON</b> c. CITY OR TOWN <b>CRYSTAL CITY</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>121 LINCOLN, ST.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>JAMES</b> Middle <b>H.</b> Last <b>GRAHAM</b>		<b>4. DATE OF DEATH</b> Month <b>11</b> Day <b>10</b> Year <b>59</b>	

<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>COLORED</b>	<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>8-4-1886</b>	<b>9. AGE</b> (last birthday) <b>73</b> IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HR Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>RETIRED GLASS WORKER</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>P. P. G. CO.</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>DEXTER, MO.</b>

<b>13a. FATHER'S NAME</b> <b>JOHN GRAHAM</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>UNKNOWN</b>	<b>14. NAME OF HUSBAND OR WIFE</b> <b>FRANCIS</b>
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	<b>16. SOCIAL SECURITY NO.</b> <b>489 03 4590</b>	<b>17. INFORMANT</b> Address <b>FRANCIS GRAHAM CRYSTAL CITY, MO.</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>Mesenteric Thrombosis</b>	DUE TO (b) <b>Neoplasm of Left Lung</b> DUE TO (c) _____	INTERVAL BETWEEN ONSET AND DEATH <b>11-10-59</b>  <b>Jan. '59.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		
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.  
 Yes  No  Unknown

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year.	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	<b>COUNTY</b> _____ <b>STATE</b> _____

21. I attended the deceased from **10-30** to **11-10-59** and last saw <sup>her</sup>him alive on **11-10-59**  
 Death occurred at **9:20 pm** on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <b>J.C. Sheard, M.D.</b>	<b>22b. ADDRESS</b> <b>2702 1/2 Franklin Ave</b>	<b>22c. DATE SIGNED</b> <b>11-12-59</b>
<b>23a. BURIAL, CREMATION, OR REMOVAL</b> (Specify) <b>BURIAL</b>	<b>23b. DATE</b> <b>11-15-59</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>MT. ZION CEMETERY</b>
<b>23d. LOCATION</b> (City, town, or county) (State) <b>CRYSTAL CITY, MO.</b>		

<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>GENTRY R. POLITTE CRYSTAL CITY, MO.</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <b>NOV 12 1959</b>	<b>26. REGISTRAR'S SIGNATURE</b> <b>Earl Smith, M.D.</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 20 1954

**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 Gentry R. Palitte

Licensed Embalmer No. 3481

P. O. Address Crystal City

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.