

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-009763

FILED VS. APR 11 1960

10

Primary Registration District No. 3002

Registrar's No. 85

STATE FILE NUMBER

ENDED

|   |   |   |   |   |   |   |  |
|---|---|---|---|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Audrain</b>   |   |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Montgomery</b> |   |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Mexico</b>  |   | Length of stay in 1b<br><b>1 day</b>  |   | c. CITY OR TOWN <b>Montgomery</b>   |   | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |  |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Audrain County Hospital</b>   |   |   |   | d. STREET ADDRESS (If outside, give location)   |   | Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Theresa</b> Middle <b>Graf</b> Last <b>Graf</b>  |   |   |   | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>4</b> Year <b>1960</b>  |   |   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>6-2-1879</b>   | 9. AGE (last birthday)<br><b>80</b>               | IF UNDER 1 YEAR<br>Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | IF UNDER 24 HR<br>Hours <input type="checkbox"/> Min. <input type="checkbox"/> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  | 11. BIRTHPLACE (City and state or country)<br><b>Austria, Hungary</b>   |   | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>   |  |
| 13a. FATHER'S NAME<br><b>Peter Graf</b>   |   |   | 13b. MOTHER'S MAIDEN NAME<br><b>Frauenhoffer</b>  |   | 14. NAME OF HUSBAND OR WIFE<br><b>None</b>        |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO.<br><b>None</b>  | 17. INFORMANT<br><b>Mrs. Leland Bocklitz</b><br>Address <b>Montgomery City Missouri</b> |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <b>Hypertension</b><br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br>PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>94 hours</b><br><b>Unknown</b>   |  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>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>Apr. 3 - 60</b> to <b>Apr. 4 - 60</b> and last saw her him alive on <b>Apr. 4, 60</b><br>Death occurred at <b>8:25 a</b> m on the date stated above, and to the best of my knowledge, from the causes stated.   |   |   |   |   |   |   |  |
| 22a. SIGNATURE<br><b>R. O. Swan</b> (Degree or title) <b>100</b>  |   |   |   | 22b. ADDRESS<br><b>Mexico, Mo</b>   |   | 22c. DATE SIGNED<br><b>4-6-60</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE<br><b>April 7, 1960</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Calvary Cemetery</b>   |   | 23d. LOCATION (City, town, or county)<br><b>St. Louis, Missouri</b>   |   | (State)   |  |
| 24. FUNERAL DIRECTOR<br><b>Schlanker Funeral Home</b><br>Address <b>Montgomery City Missouri</b>  |   |   | 25. DATE RECD. BY LOCAL REG.<br><b>April 6-1960</b>                                     |   | 26. REGISTRAR'S SIGNATURE<br><b>Blanche Neely</b> |   |  |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 E. Boone Schless

Licensed Embalmer No. 4136

P. O. Address Montgomery

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.