

**FEDERAL BUREAU OF INVESTIGATION - UNITED STATES DEPARTMENT OF JUSTICE**  
**U.S. DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS JUL 22 1960

-60-029221

ENDED

Registration District No. **317** Primary Registration District No. **500** Registrar's No. **1996** 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>Bellefontaine Wash brs</b>		Length of stay in 1b <b>12 yrs 16 days</b>	c. CITY OR TOWN <b>St. Louis Bellefontaine Wash brs</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis State School</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>10695 Bellefontaine Rd</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>LIONEL</b> Last <b>GRAF</b>			4. DATE OF DEATH Month <b>6</b> Day <b>30</b> Year <b>1960</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4-20-1926</b>	9. AGE (last birthday) <b>34 yrs</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>St. Louis</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
13a. FATHER'S NAME <b>William Lionel Graf</b>		13b. MOTHER'S MAIDEN NAME <b>Noley (Kerney) Graf</b>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NR</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Records of St. Louis State School Bellefontaine Rd</b> Address <b>10695 Bellefontaine Rd</b>	

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) <b>Hyperstatic Pneumonia</b>			<b>5 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Kypho-Scoliosis</b>	<b>since birth</b>	
	DUE TO (c) <b>Spastic Paraplegia</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Blindness</b>			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 checked="" 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>June 14, 1948</b> to <b>June 30, 1960</b> and last saw her <b>June 30, 1960</b> alive on <b>June 30, 1960</b> . Death occurred at <b>2:12 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree or title) <b>Edward P. Huff M.D.</b>	22b. ADDRESS <b>10695 Bellefontaine Rd</b>	22c. DATE SIGNED <b>6/30/60</b>
23a. BURIAL CREMATION <b>BURIAL</b>	23b. DATE <b>7/2/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CALVARY</b>
23d. LOCATION (City, town, or county) <b>ST LOUIS MO.</b>		(State)

24. FUNERAL DIRECTOR <b>Joseph A Howard</b> ADDRESS <b>1214 S BROAD B. 7-1-60</b>	25. DATE RECD. BY LOCAL REG. <b>7-1-60</b>	26. REGISTRAR'S SIGNATURE <b>J. E. Huff M.D.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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 \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Harry E. Monroe*

Licensed Embalmer No.

*4495*

P. O. Address

*St. Louis*

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.