

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri		Length of stay in 1b 29 das.	c. CITY OR TOWN Mt. Vernon
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Children's		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 521 Meadowbrook
3. NAME OF DECEASED (Type or print) First Middle Last Steven Dawayne Graham		4. DATE OF DEATH Month Day Year 10 28 60	

5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-6-58	9. AGE (last birthday) 2yrs.	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) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and state or country) Mt. Vernon, Ill.		12. CITIZEN OF WHAT COUNTRY U. S. A.
13a. FATHER'S NAME Robert F. Graham		13b. MOTHER'S MAIDEN NAME Barbara Hayes		14. NAME OF HUSBAND OR WIFE Single		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Larry Dryor	Address 500 S. Kinghighway
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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) Cerebral Anoxia		
DUE TO (b) Esophageal stricture 2° to lye ingestion		
DUE TO (c) Polypypromastomy & Transverse cologastrostomy		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Mediastinitis, Pericarditis		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 checked="" 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.) Ingested draino at home
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20c. TIME OF INJURY Hour a.m. p.m. 7 25 60	883.0 - 17
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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.) home 7F	20f. CITY, TOWN, OR LOCATION Mt. Vernon, Illinois	COUNTY	STATE
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21. I attended the deceased from 9-30-60 to 10-28-60 and last saw him ^{XXXX} alive on 10-28-60 Death occurred at 6:30 Pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Emma Purce, M.D.	22b. ADDRESS St. Louis Childrens Hosp.	22c. DATE SIGNED 10/29
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23a. BURIAL OR CREMATION REMOVAL (Specify) Removal	23b. DATE 10-29-60	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) Dix, Ill.
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24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd.	25. DATE RECD. BY LOCAL REG. OCT 31 1960	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.
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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

Robert M. Munn

Licensed Embalmer No. 3749

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.