

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. _____
FILED AUG 31 1961

DATE AMENDED _____
 INSTEAD OF _____
 DOCUMENT _____
 MEDICAL CERTIFICATION _____
 BY AFFIDAVIT OF _____
 ITEM NO. SHOULD READ _____

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b	c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5549 Hebert St.		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5549 Hebert St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First SARA Middle V. Last GRAHAM.			4. DATE OF DEATH Month AUG. Day 25 Year 1961		
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/20/1902	9. AGE (last birthday) 58	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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) Springfield Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME John Foote		13b. MOTHER'S MAIDEN NAME Emma Unknown		14. NAME OF HUSBAND OR WIFE Ralph Graham.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No. None		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Address Ralph Graham 5549 Hebert St 20		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial insufficiency rheumatic heart disease DUE TO (b) Rhoumatie haart disease DUE TO (c) 716x 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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					INTERVAL BETWEEN ONSET AND DEATH not known
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 Jan. 12, 1959 to August 25, 1961 and last saw her ^{her} alive on August 16, 1961 Death occurred at 4:45 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Raymond A. Stansbury M.D.			22b. ADDRESS 3121 N. Grand		22c. DATE SIGNED 8-26-61
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Aug. 28, 1961	23c. NAME OF CEMETERY OR CREMATORY Mount Lebanon Cemetery.		23d. LOCATION (City, town, or county) St. Louis County	STATE Mo.
24. FUNERAL DIRECTOR Calvin F. Feutz Funeral Home. St. Louis MO.		25. DATE RECD. BY LOCAL REG. AUG 26 1961	26. REGISTRAR'S SIGNATURE Roald Smith, M.D.		

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 Robert E. Mullen

Licensed Embalmer No. 4916

P. O. Address St. Louis, Mo.

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.