

U. S. No. 2
FORM-5-43
Rev. 5-17-39
X 36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. 11270
Registrar's No. 3087

FILED APR 23 1945
818
Registration District No. _____

Primary Registration District No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis City Hospital #1.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution lmo-18days
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 1606 Menard Str
(If rural, give location)

(e) Citizen of foreign country? No 17 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MAGDALENE GRAF

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Anton Graf 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased Dec. 9 1881
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

63	3	25	_____ hr. _____ min.
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9. Birthplace Hungary
(City, town, or county) (State or foreign country)

10. Usual occupation Factory Worker

11. Industry or business St. Louis Cordage Mills

12. Name Nicloas Kipp

13. Birthplace Hungary
(City, town, or county) (State or foreign country)

14. Maiden name Anna

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Anton Graf

(b) Address 1606 Menard Str.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/7/45
(Month) (Day) (Year)

(c) Place: burial or cremation S. S. Peter & Paul

18. (a) Signature of funeral director Wm. E. Magdell

(b) Address 1926 Allen Ave

19. (a) APR 6 1945 (Date received local registrar) (b) J. F. Bruck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 4th
year 1945 hour 8:55 minute _____ P. M.

21. I hereby certify that I attended the deceased from 3/17/45
_____ 19, to 3/4/45 19;
that I last saw h er alive on 3/4/45 19;
and that death occurred on the date and hour stated above.

Immediate cause of death Cathexia

Due to Carbons of rectum, recurrent locally after abdominal periton.

Due to rectum

Other conditions 46
(Include pregnancy within 3 months of death)

Major findings: Local recurrence of site of adenocarcinoma of rectum

Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J. F. Bruck 1515 Lafayette 4/5/45
(M. P. or other) Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 me

Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Licensed Embalmer No. 3741

P. O. Address 1926 Allen ave.

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 this body is not embalmed, fact should be so stated above.