

FILED MAY 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13781**
3601

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital		d. STREET ADDRESS (If rural, give location) 4844 Leduc St.	

3. NAME OF DECEASED (Type or Print) a. (First) Harry b. (Middle) - c. (Last) Graves			4. DATE OF DEATH (Month) (Day) (Year) Apr. 20, 1949			
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Apr. 14, 1872	9. AGE (In years last birthday) 77	IF UNDER 1 YEAR Months Days	IF UNDER 6 mos. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Street Car Operator		10b. KIND OF BUSINESS OR INDUSTRY retired		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME Alfred Graves		13b. MOTHER'S MAIDEN NAME Elizabeth Unknown		14. NAME OF HUSBAND OR WIFE Cora L. Graves	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Cora L. Graves - 4844 Leduc St.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Protektorial Obstruction		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Polycystic of Intestines		
	DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION as above		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR

22. I hereby certify that I attended the deceased from **4-16-49** to **4-20-49**, that I last saw the deceased alive on **4-20-49**, and that death occurred at **3:10 Pm.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) R. K. ...		23b. ADDRESS 3903 Park Ave		23c. DATE SIGNED 4-22-49
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE Apr. 22, 1949	24c. NAME OF CEMETERY OR CREMATORY Roll	24d. LOCATION (City, town, or county) (State) Oklahoma City, Okla.	

DATE REC'D BY LOCAL REG APR 22 1949	REGISTRAR'S SIGNATURE J. B. ...	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Drehmann-Harral - 1905 Union Blvd.
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD. Via H.R. to Oklahoma City, Okla.

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Dr. R. F. Hyland (8-11)
3901a Park Ave.

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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.

Signed
Student Embalmer

Signed _____

Albert R. Thompson

Licensed Embalmer No. _____

4237

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