

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21073**
Registrar's No. **5586**

FILED JUL 9 1949

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY MO		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis Mo		c. LENGTH OF STAY (in this place) 0	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		17
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital			d. STREET ADDRESS (If rural, give location) 27-20 N. COMPTON AVE		
3. NAME OF DECEASED (Type or Print) a. (First) William		b. (Middle) _____		c. (Last) Graham	
4. DATE OF DEATH (Month) (Day) (Year) June 26 1949					
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widow	8. DATE OF BIRTH 1863	9. AGE (in years) (Specify birthday) 86	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) Unknown	
12. CITIZEN OF WHAT COUNTRY? 9					
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		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) NO		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Theodore Morton ADDRESS 6508 Delmar	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Congestion and Edema		DUE TO (b) Hypertensive Heart Disease			Undet.
*This does not mean the mode of dying, such as heart failure, asystolia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cystitis Hemorrhagica					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) St. Louis MO	
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? Hit by car	

22. I hereby certify that I attended the deceased from June 18, 1949, to June 26, 1949, that I last saw the deceased alive on June 26, 1949, and that death occurred at 6:10a m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Mrs. J. Pedrick M.D.		23b. ADDRESS 2601 N Whittier St		23c. DATE SIGNED June 27, 1949	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 6-29-49		24c. NAME OF CEMETERY OR CREMATORY Oakdale	
				24d. LOCATION (City, town, or county) (State) St. Louis County MO	

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE J. B. Forster		25. FUNERAL DIRECTOR'S SIGNATURE D. Wade Granberg ADDRESS 4202 Finney	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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
Student Embalmer

Signed Leroy W. Barnister

Licensed Embalmer No. 4523

P. O. Address 3880th Easton A

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.