

FILED SEP 16 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 31829

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. <u>7967</u>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) <u>20 yrs</u>		c. CITY OR TOWN <u>St. Louis</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION. <u>5523 Alaska Ave.</u>				e. STREET ADDRESS (If rural, give location) <u>15 5523 Alaska Ave. 21590</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Josephine</u> b. (Middle) _____ c. (Last) <u>Graesser</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>August 27 1954</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 29 1884</u>		9. AGE (In years last birthday) <u>70</u>	10. UNDER 1 YEAR Months <u>3</u> Days <u>28</u>	11. UNDER 10 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work denoting most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Fred Carstens</u>			13b. MOTHER'S MAIDEN NAME <u>Wilhelmina Hiloot</u>		14. NAME OF HUSBAND OR WIFE <u>Louis Graesser</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Louis Graesser 5523 Alaska Ave.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebro vascular accident</u>					
		ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u>					
		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 _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT (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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>331X</u>			
22. I hereby certify that I attended the deceased from <u>1949</u> to <u>27 Aug</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>27 Aug</u> , 19 <u>54</u> , and that death occurred at <u>2:00 P</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Charles S. [Signature] M.D.</u>				23b. ADDRESS <u>4252 Maryland Ave.</u>		23c. DATE SIGNED <u>28 Aug 54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>8/30/1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Lakewood Park Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo.</u>		
DATE REC'D BY LOCAL REG. <u>AUG 30 1954</u>		REGISTRAR'S SIGNATURE <u>J. Earl Smith, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J.L. Ziegenhein &amp; Sons 7027 Gravois</u>			

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

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1923

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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..

Student.....  
Signature of Student Embalmer



Signed G. F. Kidwell

Licensed Embalmer No. 387

P. O. Address 7027 Gr

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.