

Health,
Welfare
Public
Service

300
1-56

Most use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED JUL 31 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26143

STATE FILE NUMBER

6834

Registration District No. **318** Primary Registration District No. **1003**

Registrar's No.

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|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI | | c. CITY OR TOWN GRANITE CITY | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL | | d. STREET ADDRESS 2853A WASHINGTON | |

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|-------------------------------------|----------------------|-----------------------|--------------------|------------------|-------------------|---------------|------------------|
| 3. NAME OF DECEASED (Type or print) | First WILLIAM | Middle FRANCIS | Last GRAHAM | 4. DATE OF DEATH | Month JULY | Day 20 | Year 1957 |
|-------------------------------------|----------------------|-----------------------|--------------------|------------------|-------------------|---------------|------------------|

| | | | | | | |
|--------------------|-------------------------------|---|-----------------------------------|---|-----------------|------------------|
| 5. SEX MALE | 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 2-12-1900 | 9. AGE (In years last birthday) 57 | IF UNDER 1 YEAR | IF UNDER 24 HRS. |
|--------------------|-------------------------------|---|-----------------------------------|---|-----------------|------------------|

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|--|---|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN | 10b. KIND OF BUSINESS OR INDUSTRY AMERICAN STEEL | 11. BIRTHPLACE (City and state or country) E. ST. LOUIS, ILL. | 12. CITIZEN OF WHAT COUNTRY? U.S. |
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| 13. FATHER'S NAME MICHEAL J. GRAHAM | 14. MOTHER'S MAIDEN NAME LAURA ANN ASTORE |
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| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give year or dates of service) WW I | 16. SOCIAL SECURITY NO. 335-10-5352 | 17. INFORMANT Agnes Graham Address 2853A Washington St Granite City Ill |
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| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED CARCINOMATOSIS (PRIMARY SITE UNKNOWN) | | INTERVAL BETWEEN ONSET AND DEATH 3 MOS.? |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | DUE TO (b) |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | DUE TO (c) |

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| 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. _____ | 20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) |
| 20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20f. CITY, TOWN, OR LOCATION COUNTY STATE |

21. I attended the deceased from **JULY 13, 1957** to **JULY 20, 1957** and last saw her alive on **JULY 20, 1957**
 Death occurred at **2:00 A.M.** m on the date stated above; and to the best of my knowledge, from the causes stated.

| | | |
|--|-------------------------------------|---------------------------------|
| 22a. SIGNATURE FR Pringle (Degree or title) M.D. | 22b. ADDRESS BARNES HOSPITAL | 22c. DATE SIGNED 7/20/57 |
|--|-------------------------------------|---------------------------------|

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|--|----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | 23b. DATE 7-20-1957 | 23c. NAME OF CEMETERY OR CREMATORY MT. CARMEL | 23d. LOCATION (City, town, or county) (State) BELLEVILLE, ILLINOIS |
|--|----------------------------|--|---|

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| 24. FUNERAL DIRECTOR Frank Messer ADDRESS Frank Coyle | 25. DATE RECD. BY LOCAL REG. JUL 22 57 | 26. REGISTRAR'S SIGNATURE Carl Smith |
|---|---|---|

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STATE OF TEXAS
DEPARTMENT OF HEALTH
BUREAU OF PUBLIC HEALTH

ST
MAY 1 4 1959

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 *Charles E. Meese*.....

Licensed Embalmer No. *2*
P. O. Address *Frank City*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.