Health, Welfare Public Service

300 0
1-56

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 33561 8179

FILED SEP 17 1957

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION City Hospital — Length of stay in 1b 14 hours

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY
c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
STREET ADDRESS 4207 Arco (If outside, give location) — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Edward Middle Eddie Last Graves
4. DATE OF DEATH Month September Day 2 Year 1957
5. SEX male
6. COLOR OR RACE white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Dec. 9, 1905
9. AGE (In years last birthday) 51 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker
10b. KIND OF BUSINESS OR INDUSTRY Scullin Steel Co.
11. BIRTHPLACE (City and state or country) St. Louis, Missouri.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Austin Graves
14. MOTHER'S MAIDEN NAME Margarette Dehering
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 492-09-4085
17. INFORMANT Address Mr. John Graves 6817 Balson

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1. Pulmonary Congestion
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) 2. Cirrhosis of the liver
DUE TO (c) 3. Cardiac Hypertrophy

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 5810

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from _____, to _____ and last saw her/him alive on _____. Death occurred at 6:40 A.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [signature] (Degree or title) M.D.
22b. ADDRESS 1300 Clark
22c. DATE SIGNED 9/3/57

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 9-4-57
23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery
23d. LOCATION (City, town, or county) Normandy, Missouri. (State)

24. FUNERAL DIRECTOR Math Hermann & Son, Inc. ADDRESS 2161 E. Fair
25. DATE RECD. BY LOCAL REG. SEP 3 '57
26. REGISTRAR'S SIGNATURE Carl Smith M.D.

(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 em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student .....
Signature of Student Embalmer

Signed Clement M. Mar

Licensed Embalmer No. 37

P. O. Address St. Lou

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.