

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS DEC 22 1959**

'59 0 4 4 5 5 1

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. 3021 Registrar's No. 91

1. PLACE OF DEATH a. COUNTY <u>JEFFERSON</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>JEFF</u>									
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>De Soto</u>		Length of stay in 1b <u>30 YRS</u>		c. CITY OR TOWN <u>De Soto</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>803 S. 5TH. ST.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>803 S. 5TH. ST.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>FRANCIS</u> Middle <u>EDWARD</u> Last <u>GRAHAM</u>				4. DATE OF DEATH Month <u>DEC.</u> Day <u>12</u> Year <u>1959</u>									
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 18, 1889</u>		9. AGE (last birthday) <u>74</u>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (City and state or country) <u>CEDAR HILL Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13a. FATHER'S NAME <u>LAFAYETTE GRAHAM</u>				13b. MOTHER'S MAIDEN NAME <u>ELIZABETH HELTERBRAND</u>				14. NAME OF HUSBAND OR WIFE <u>LAURA GRAHAM</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>NO</u>		17. INFORMANT Address <u>WALTER GRAHAM, 925 WACHTEL LEMAY, Mo.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arteriosclerosis of coronary arteries</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown										INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hours</u> <u>unknown</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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. Month, Day, Year _____													
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <u>Dec 12, 1959</u> to <u>Dec 12, 1959</u> and last saw him alive on <u>Dec 12, 1959</u> Death occurred at <u>10:40 Pm</u> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>Thomas G. Donnell M.D.</u>						22b. ADDRESS <u>De Soto Mo</u>			22c. DATE SIGNED <u>12-14-59</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>Dec 15 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN</u>		23d. LOCATION (City, town, or county) <u>De Soto</u>		(State) <u>Mo.</u>					
24. FUNERAL DIRECTOR <u>DIETRICH F. HOME, De Soto Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>Dec. 15-1959</u>		26. REGISTRAR'S SIGNATURE <u>Marie Loria</u>							

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF

**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 Donnell Fred Dietrich, Student Embalmer No. 588  
working under my personal supervision.

Student Donnell Fred Dietrich Signed Donnell B. Dietrich  
Signature of Student Embalmer

Licensed Embalmer No. 4104

P. O. Address Delato

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.