

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER **-61-038619**

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9769**

**FILED NOV 8 1961**

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Saint Louis (18)</b>               |  | Length of stay in 1b<br><b>1 Day</b>  | c. CITY OR TOWN <b>Saint Louis (11)</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>St. Anthony Hospital</b> |  | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location) <b>4686 Tennessee Ave.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

|   |                                  |   |  |  |  |
|---|----------------------------------|---|--|--|--|
| 3. NAME OF DECEASED (Type or print)<br>First <b>LILLIAN</b> Middle <b>GRABER</b> Last                           |                                  |   | 4. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>21</b> Year <b>1961</b> |  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10/15/87</b>                                  | 9. AGE (last birthday)<br><b>74</b>                  | IF UNDER 1 YEAR IF UNDER 24 HR<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housework</b> |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>   | 11. BIRTHPLACE (City and state or country)<br><b>St. Louis, Mo.</b>  | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>         |  |
| 13a. FATHER'S NAME<br><b>William Brearley</b>   |                                  | 13b. MOTHER'S MAIDEN NAME<br><b>Laura Stendel</b>   |  | 14. NAME OF HUSBAND OR WIFE<br><b>William Graber</b> |  |

|   |  |   |
|---|--|---|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b> | 16. SOCIAL SECURITY NO.<br><b>None</b> | 17. INFORMANT Address<br><b>William Graber 4686 Tennessee Ave. (11)</b> |
|---|--|---|

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *Fracture of right hip; Generalized Arteriosclerosis; apparently suffered in fall; exact time and place unknown. Accident*

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) *unknown. Accident*

DUE TO (c) *unknown. Accident*

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)  
**904.9 - 45**

PART III. If deceased was female was there a pregnancy in last 90 days.  
 Yes  No  Unknown

|  |  |  |
|--|--|--|
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input checked="" 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 Month, Day, Year  
a.m. **unk.** p.m.

|  |   |   |        |       |
|--|---|---|--------|-------|
| 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.)<br><b>00 unk</b> | 20f. CITY, TOWN, OR LOCATION<br><b>unk.</b> | COUNTY | STATE |
|--|---|---|--------|-------|

21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at **9:30 a.** m on the date stated above, and to the best of my knowledge, from the causes stated.

|  |                                       |                                     |
|--|---------------------------------------|-------------------------------------|
| 22a. SIGNATURE (Degree or title)<br><b>Nelson L. Taylor, Coroner</b> | 22b. ADDRESS<br><b>1300 Clark Ave</b> | 22c. DATE SIGNED<br><b>10-23-61</b> |
|--|---------------------------------------|-------------------------------------|

|   |                                   |   |  |
|---|-----------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b> | 23b. DATE<br><b>Oct. 24, 1961</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Park Lawn Cemetery</b> | 23d. LOCATION (City, town, or county) (State)<br><b>Lemay (25) Mo.</b> |
|---|-----------------------------------|---|--|

|   |  |  |
|---|--|--|
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Fendler Und. Co. 7420 Michigan Ave. (11)</b> | 25. DATE RECD. BY LOCAL REG.<br><b>OCT 23 1961</b> | 26. REGISTRAR'S SIGNATURE<br><b>Earl Smith. M.D.</b> |
|---|--|--|

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1300 Elm Ave

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 W. G. Peterson

Licensed Embalmer No. 3767

P. O. Address 7420 Michigan

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.