MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

41032

1. PLACE OF DEATH

County ..... Registration District No. 791 1003 File No. 11691

Township ..... Primary Registration District No. ..... Registered No. .....

City St. Louis, Mo. (No. City Hospital #2 St. ..... Ward)

2. FULL NAME FREDDIE GRAHAM

(a) Residence. No. 110 S. GARRISON St., 18 Ward. (If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 13 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: MALE
4. COLOR OR RACE: COL.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): SINGLE

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ——

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10-28-1929

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
1	1	13	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work NONE

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St. Louis (STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER JAMES GRAHAM

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) MISS

12. MAIDEN NAME OF MOTHER JERNTHY DANIELS

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) MISS

14. INFORMANT A. GERTRUDE CREATH (Address) CITY HOSPITAL #2

15. FILED ..... 19.. Max C. Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-11-1930

17. I HEREBY CERTIFY, That I attended deceased from 11-17-1930, to 12-11-1930, that I last saw him alive on 12-11-1930, and that death occurred, on the date stated above, at 3:05 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Bronchitis 106A (NON-T.B.)

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (SECONDARY) Malnutrition

(duration) yrs. 6 mos. ds.

18. WHERE WAS DISEASE CONTRACTED? IF NOT AT PLACE OF DEATH? UNKNOWN

DID AN OPERATION PRECEDE DEATH? NO. DATE OF .....

WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS? CLINICAL - X-RAY

(Signed) Henry C. Hampton, M. D

12-14 1930 (Address) City Hosp. #2

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION OR REMOVAL: Washington Park Cem — DATE OF BURIAL: 12/15 1930

20. UNDERTAKER: Peoples Und Co — ADDRESS: 3100 Franklin

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No.....,.....St. .....Ward)

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19.....
that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
.....(duration).....yrs. .....mos.....ds.

CONTRIBUTORY .....
(SECONDARY)
.....(duration).....yrs. .....mos.....ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) ....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.