

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

Do not use this space.

✓ 19821
File No. _____
Registered No. **5846**
St. _____ Ward)

1. PLACE OF DEATH

County _____ Registration District No. **791**
Township _____ Primary Registration District No. **1006**
City **St. Louis Mo** (No. **City Hospital #2**)

2. FULL NAME **Robert Graham**

(a) Residence No. **1219 Elliott** St. **21** Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **3** yrs. mos. 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) **unknown**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
alt. 24 - - -

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Laborer 459**
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ann**

10. NAME OF FATHER **Anderson Graham**

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

12. MAIDEN NAME OF MOTHER **Georgia Mays**

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

14. INFORMANT **A Gertrude Creath** (Address) **City Hospital #2**

15. FILED **21** 19**31** **Walter Richter** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **5-16** 19**31**

17. I HEREBY CERTIFY, That I attended deceased from **3-20**, 19**31**, to **5-16**, 19**31**, that I last saw him alive on **5-16**, 19**31**, and that death occurred, on the date stated above, at **4:50 a** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic nephritis
1931 (duration) **1** yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **131** (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED **Home**
IF NOT AT PLACE OF DEATH.

0 DID AN OPERATION PRECEDE DEATH? **no** DATE OF _____

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS? **Urin, 9 Lab**
(Signed) **R. A. Welches**, M. D.

5/18, 19**31** (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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Washington U.** DATE OF BURIAL **5-20 1931**

20. UNDERTAKER **Walter Richter** ADDRESS **3500 Putney St**

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.

