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

Do not use this space.

25606

File No. 77

Registered No.

1. PLACE OF DEATH

County: Macon — Registration District No.: 233.

Township: Hudson — Primary Registration District No.: 2713.

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

2. FULL NAME: Mrs Helen Graham

(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)
Female	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Dec 15 1882

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	6	17	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

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

(c) Name of employer: .....

9. BIRTHPLACE (CITY OR TOWN): La Fayette
(STATE OR COUNTRY): Indiana

PARENTS

10. NAME OF FATHER: Chas R. Underwood

11. BIRTHPLACE OF FATHER (CITY OR TOWN): Indiana
(STATE OR COUNTRY): ~~Winona P. Chute~~

12. MAIDEN NAME OF MOTHER: Winona P Chute

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

14. INFORMANT: W. A. Graham
(Address): La Fayette Ind.

15. FILED 7/13 1931 Mrs Luke Hunkler, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR): July 2 1931

17. I HEREBY CERTIFY, That I attended deceased from A.M. 19 ..... 1929, to July 2 1931 that I last saw her alive on July 2 1931, and that death occurred, on the date stated above, at 5:30 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage
82A
85 (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (SECONDARY): Epilepsy (duration) 12 yrs. 2 mos. ..... ds.

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

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

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical Symptoms

(Signed) F. M. Stell M.D.

7/2 1931 (Address) Macon, Mo.

*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: Springvale La Fayette Indiana — DATE OF BURIAL: July 3 1931

20. UNDERTAKER: Albert Skinner — ADDRESS: Macon Mo

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.

MAY 6 1947