

MAR 24 1934

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

Do not use this space.

1. PLACE OF DEATH

County *Mississippi*
Township *Fayette*
City *Charleston Mo* (No.)

Registration District No. *566*
Primary Registration District No. *3030*

File No. *5762*
Registered No. *15*
St. Ward)

2. FULL NAME

Bertha Mae Graham
(a) Residence, No. *North Reggie* 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 *female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *married*

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Claude Graham*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *May 14 - 1898*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
25 8 20

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *housewife*
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Stoddard County Mo.*

13. NAME *W M Jackson*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo.*

15. MAIDEN NAME *Carrie Nathan*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Belmont Mo.*

17. INFORMANT *Husband - Claude Graham* (ADDRESS) *Charleston Mo.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Oak Grove* DATE *Feb 4 1934*

19. UNDERTAKER *Charleston Funeral & Undertaking Co.* (ADDRESS) *Charleston Mo.*

20. FILED *Feb 4 1934* *F D Vernon* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Feb 4 1934*

22. I HEREBY CERTIFY, That I attended deceased from

I last saw him alive on *No Doctor* 19..... Death is said to have occurred on the date stated above, at

The principal cause of death and related causes of importance were as follows:
C Clampra
1911
Other contributory causes of importance: *no*

Name of operation Date of

What test confirmed diagnosis? *staphylococcus* Was there an autopsy? *no*

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury

Where did injury occur? (Specify city or town, county, and State) *Home*

Specify whether injury occurred in industry, in home, or in public place. Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? If so, specify *Paul Hackney*

(Signed) *Paul Hackney* (Address) *Charleston Mo, Coroner*

(Address) *Charleston Mo, Coroner*

RECORD
IF
be stated EXACTLY.
Statement of OCCUR
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH, in terms, so that it may be properly classified. Exact statement of OCCUR

23
X
1

MPD
MSM

#2
Mississippi

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS *5762*

WASHINGTON

E. T. McGaugh, M. D.,
Special Agent,
Jefferson City, Mo.

15 -

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Bertha Mae Graham
Who died at _____ on Feb - 4 - 1934
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex F Color or race W ~~Single~~; married, widowed or divorced: _____

Date of birth _____ Age: Years 35 - Months 8 Days 20

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____ (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

Date deceased last worked at this occupation: Month _____ Year _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

Principal cause of death: Eclampsia
It was Puerperal Eclampsia

Other contributory causes of importance _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____

(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

Name of physician _____

Address of physician _____

Signature of Registrar Frank D. Brown Date filed 9/20/34

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. 566

Very truly yours,

Primary Reg. Dist. No. 3030

E. T. McGaugh, M.D.

Special Agent.

K.

