

REC'D MAY 1 0 1938

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

13300

Do not use this space.

3904

1. PLACE OF DEATH

- (a) County..... Registration District No. **791**
(b) Township..... Primary Registration District No. **1003**
(c) City St. Louis, Mo. (d) Street No. City Hospital #1 St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Robert Graham 650

- (a) Residence, No. 3938 Page St. 11
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widower		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>11/19/1877</u>				
7. AGE YEARS 60	MONTHS 4	DAYS 23	If LESS than 1 day, hrs. or min.	
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Nil			
	9. Industry or business in which work was done, as saw mill, bank, etc.			
	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) <u>Mo.</u>				
FATHER	13. NAME <u>John Graham</u>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Scotland</u>			
MOTHER	15. MAIDEN NAME <u>Margaret Harris</u>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Scotland</u>			
17. INFORMANT <u>Hosp. info. M. Williams</u> (ADDRESS) <u>City Hospital #1</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>City Cemetery</u> DATE <u>4-28-38</u>				
19. FUNERAL DIRECTOR (NAME) <u>Frank Frazer</u> (ADDRESS) <u>City Hospital, Morgan</u>				
20. FILED <u>APR 27 1938</u> <u>J. F. Budick</u> Local Registrar				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4/12/38 19..

22. I HEREBY CERTIFY, That I attended deceased from 1/19/38 19.. to 4/12/38 19..
I last saw him alive on 4/12/38 19.. Death is said to have occurred on the date stated above, at 7:20 P. M.
The principal cause of death and related causes of importance were as follows:
Broncho-genic Carcinoma
Cachexia
Other contributory causes of importance: MI

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy? yes

23. 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.....

24. Was disease or injury in any way related to occupation of deceased?.....
If so, specify.....
(Signed) Dr. Maxwell, M. D.
(Address) 1515 Lafayette

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

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.