

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.

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

19957
Do not use this space.

REC'D JUL 12 1938

1. PLACE OF DEATH

(a) County Registration District No. **751**
(b) Township Primary Registration District No. **1003**
(c) City **St. Louis** (d) Street No. **City Hospital No. 1** Registered No. **5096**
(If death occurred in Hospital or Institution, write its name instead of street and number) St.
(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.

D 2854

2. PRINT FULL NAME

Mattie Graham **650**
(a) Residence, No. **1522 1/2 Menard St.** **23** (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **female**
4. COLOR OR RACE **white**
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Widowed**
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Widowed Wife of Marion**
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Sept 30 1865**
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
72 **8** **2**
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Housewife**
9. Industry or business in which work was done, as saw mill, bank, etc. **nil**
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) **Missouri**

13. NAME **Wm. Billings**

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

15. MAIDEN NAME **Sarah ?**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**

17. INFORMANT **Hosp. INfo M. Kent**
(ADDRESS)

18. BURIAL, CREMATION OR DISPOSAL in **Lakewood Park** DATE **May 4, 1938**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **R. W. McLaughlin**
2301 Lafayette Avenue

20. FILED **SUN 9 1938** **J. F. Wredeck**
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **6/2/38** 19

22. I HEREBY CERTIFY, That I attended deceased from **5/28/38** to **6/2/38**, 19.....
I last saw him/her live on **6/2/38**, 19..... Death is said to have occurred on the date stated above, at **5.10 a.**

The principal cause of death and related causes of importance were as follows:

Cerebral Thrombosis
(left internal capsule)
Hypertension
Cerebral Arterio sclerosis

Other contributory causes of importance:

Name of operation Date of
What test confirmed diagnosis? 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 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 **E. H. Trumbidge Jr.** M. D.
(Signed) **E. H. Trumbidge Jr.**
(Address) **City Hospital No. 1**

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,

L. R. Cooper

....., or by

Registered Apprentice No., working under my personal supervision.

Signed.....

L. R. Cooper

Licensed Embalmer No.

3633

P. O. Address.....

2317 Lafayette

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.