

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

27358

State File No. _____

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **7252**

1. PLACE OF DEATH:

(a) County _____

(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **Homer G. Phillips Hosp.**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME **Graham** **650**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **7-20-40**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
				17 hr. 10 min.

9. Birthplace **St. Louis Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name **Samuel Graham**

13. Birthplace **St. Louis, Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name **Hattie Chandler**

15. Birthplace **St. Louis, Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **E. M. Shepard**

(b) Address **2601 N Whittier**

17. (a) **Burial** (b) Date thereof **8-29-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **City Cem**

18. (a) Signature of funeral director **Alva Hammett**

(b) Address **City Health Dept**

19. (a) **AUG 28 1940** (b) **[Signature]**
(Date of death) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County _____

(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")

(d) Street No. **3226a Pine**
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **7-** day **20**
year **40** hour **11** minute **55 P.M.**

21. I hereby certify that I attended the deceased from **7-20-** **1940** to **7-20-** **1940**;
that I last saw her alive on **7-20-40**, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Autopsy (Prematurity)**

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **[Signature]** (M. D. or other) _____

Address **2601 N Whittier** Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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, fact should be so stated above.