

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **29440**

FILED SEP 8 1941

Registration District No. 78

Primary Registration District No. 200

Registrar's No. 1808

1. PLACE OF DEATH:

(a) County St. Louis / Maple
(b) City or town Camden / Maple
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Koch Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 18 days
In this community Life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 2834 a Franklin
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 29
year 1941 hour 5:00 minute A.M.
21. I hereby certify that I attended the deceased from July 1, 1941
1941 to August 29 1941.
that I last saw her alive on August 28 1941.
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Pulmonary Tuberculosis Duration 6 mo.

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

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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 Richard D. Parland (M. D. or other) _____
Address Koch Hospital Date signed 8-29-41

3. (a) PRINT FULL NAME FANNIE GRAHAM

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

4. Sex F 5. Color or race N 6. (a) Single widowed, married, divorced 1

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

7. Birth date of deceased November 15 1927
(Month) (Day) (Year)

8. AGE: Years 13 Months 9 Days 14 If less than one day _____ hr. _____ min.

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

10. Usual occupation Student

11. Industry or business _____

12. Name Julius Graham

13. Birthplace Not known, Arkansas
(City, town, or county) (State or foreign country)

14. Maiden name Estelle ?

15. Birthplace ? ?
(City, town, or county) (State or foreign country)

16. (a) Informant Estelle Nelson (sister mother)

(b) Address 2834 a Franklin

17. (a) Burial (b) Date thereof Sept 3rd 41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Father Dickson Bem

18. (a) Signature of funeral director Ellis Fun Home

(b) Address 2820 Stoddard St

19. (a) SEP - 2 1941 (b) W. M. Graham Jr.
(Date received local registrar) (Registrar's signature)

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

600

SEP 12 1941

SEP 30 1941

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

L. Boyer

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

Signed *Louise Boyer*

Licensed Embalmer No. *2946*

P. O. Address *H. Lees and Co*

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.