

Registration District No. 480Primary Registration District No. 5633

Registrar's No.

129

1. PLACE OF DEATH:

(a) County Lawrence
 (b) City or town Mt. Vernon, Missouri
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Missouri State Sanatorium
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1272 days
 (Specify whether years, months or days)
 In this community 1272 days

3. (a) PRINT FULL NAME Oscar Lewis Graham3. (b) If veteran, name war Unknown 3. (c) Social Security No. Unknown4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive Unknown7. Birth date of deceased August 27th 1874
(Month) (Day) (Year)8. AGE: Years 67 Months 0 Days 6 If less than one day
hr. min.9. Birthplace Stockton, Missouri
(City, town, or county) (State or foreign country)10. Usual occupation Farmer11. Industry or business Y12. Name Robert M. Graham13. Birthplace Nancy, L. V. Stockton, Mo
(City, town, or county) (State or foreign country)14. Maiden name Nancy J. Prieze15. Birthplace Bear Creek, Missouri
(City, town, or county) (State or foreign country)16. (a) Informant E. McMichael, Record Clerk(b) Address Missouri State Sanatorium17. (a) Removal (b) Date thereof 9 2 1941
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Stockton, Mo18. (a) Signature of funeral director Mc Davist(b) Address Stockton, Mo.19. (a) 9-2-1941 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cedar
 (c) City or town Stockton
 (If outside city or town limits, write "RURAL")
 (d) Street No. 0
 (If rural, give location)
 (e) Citizen of foreign country? / (Yes or No)
 If yes, name country /

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 2
year 1941 hour 5:00 minute 2 M.

21. I hereby certify that I attended the deceased from

March 8th 1938 to Sept 2 1941
that I last saw him alive on Sept 1st
and that death occurred on the date and hour stated above.

Immediate cause of death

Pulmonary Hemorrhage Duration 2 weeks
Pulmonary tuberculosis abt 4 years

Due to

Other conditions
(Include pregnancy within 3 months of death)Major findings:
Of operations 13B

Of autopsy

Duration

abt
4 years

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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?
 (Specify type of place) _____ (Means of injury) _____

While at work?

23. Signature W. L. Coffman (M. D. or other) M.D.
Address W. L. Coffman Date signed 9-2-41

RECEIVED

District Health Officer No. 6,

District File Number 1041-1552

Date Filed OCT 6 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.....
..... Registered Apprentice No.....
working under my personal supervision.

Signed.....

Geo B Orr

Licensed Embalmer No.....

946

P. O. Address.....

Mr Vernon

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.

STANDARD CERTIFICATE OF DEATH

State File No. 31933

Registration District No. 470

Primary Registration District No. 5633

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Lawrence
- (b) City or town St. Vernon
(If outside city or town limits, write "RURAL" and name of township)
- (c) Name of hospital or institution: _____
(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)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME Oscar L. Graham

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced w

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

7. Birth date of deceased aug 27 1874
(Month) (Day) (Year)

8. AGE: Years 67 Months 0 Days 0 If less than one day, hr. min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry of business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 9-2-1941 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept Day 27 Year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

DEC 29 1941

1941

5-31933