

V. S. No. 2  
100M-5-43  
Rev. 5-17-39  
I X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

**FILED AUG 9 1945 STANDARD CERTIFICATE OF DEATH**

State File No. 23677

Registration District No. 5-5

Primary Registration District No. 3011

Registrar's No. 67

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

17  
1  
1

**1. PLACE OF DEATH:**

(a) County Carroll  
 (b) City or town Carrollton  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Atwood Hosp  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 8 days  
 In this community most of her life (Specify whether years, months or days)

3. (a) PRINT FULL NAME Louella J Graham  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced Widow  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased. 10 20 1849  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
95 8 29 hr. min.

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

10. Usual occupation House Keeper

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Thomas Garrett

13. Birthplace Don't Know (City, town, or county) (State or foreign country) 9

14. Maiden name Parris

15. Birthplace Don't Know (City, town, or county) (State or foreign country) 9

16. (a) Informant P. E. Graham

(b) Address Bogard Mo

17. (a) Burial (b) Date thereof 7-20-45  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cheney

18. (a) Signature of funeral director E. P. Dickerson

(b) Address Bogard Mo

19. (a) 7-19-45 (b) Mrs James Rafferty  
 (Date received local registrar) (Registrar's signature)

1035

(Licensed Embalmer's Statement on Reverse Side)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State MO (b) County Carroll  
 (c) City or town Carrollton Bogard  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) Citizen of foreign country? NO (Yes or No)  
 If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month July day 19<sup>th</sup>  
 year 1945 hour 2 minute 06 A M.  
 21. I hereby certify that I attended the deceased from 7/10/45  
 that I last saw her alive on 7-18 1945  
 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration  
Cerebral Hemorrhage 10  
Hypertension days  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings:  
 Of operations: (Bis)  
 Of autopsy: (Bis)

**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 W.S. Atwood (M. D. or other)  
 Address Carrollton Mo Date signed 7/19/45

RECEIVED

District Health Officer No. 8,

File Number

Date Filed

8-8-45

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

*E. H. Decker*

Licensed Embalmer No.

2534

P. O. Address

*Bozard ma*

**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.