

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 20 1946
318

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18433**
Registrar's No. **4188**

Registration District No. _____ Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St. Louis City Hospital**
(If not to hospital or institution, write street number or location) **Max G. Starkloff Memorial**
(d) Length of stay: in hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **3756 West Pine Blvd.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **NANCY GRAHAM**
3. (b) If veteran, name war **Nil**
3. (c) Social Security No. **Unknown**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **May** day **6**
year **1946** hour **9:30** minute **A** M.

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Raymond Graham**
6. (c) Age of husband or wife if alive **26** years
7. Birth date of deceased **January 15 1920**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **April 25, 1946** to **May 6, 1946**
that I last saw h. **er** alive on **May 6, 1946**
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
26 3 21 hr. min.

Immediate cause of death **Respiratory failure**
Due to **Acute TBC 7 months advanced**
Due to _____

9. Birthplace **Iuka Mississippi**
(City, town, or county) (State or foreign country)
10. Usual occupation **Factory Worker**

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

11. Industry or business _____
12. Name **Charlie Wren**
13. Birthplace **Unknown Tennessee**
(City, town, or county) (State or foreign country)
14. Maiden name **Laura Floyd**

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

15. Birthplace **Unknown Unknown**
(City, town, or county) (State or foreign country)
16. (a) Informant **Raymond Graham**
(b) Address **3756 West Pine Blvd.**

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? _____

(a) **Removal** (b) Date thereof **5-8-46**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Paragould, Arkansas**
18. (a) Signature of funeral director **Albert H. Hoppe**
(b) Address **4700 Washington Blvd.**
19. (a) **MAY 8 1946 J. F. Bredeek**
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature **J. Thomas** (M. D. or other)
Address **1515 Lafayette Avenue** Date signed **5/6/46**

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

17311

8877

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..... *Elmo R. Padwell*

Licensed Embalmer No..... *4077*

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.