

FILED AUG 14 1947

Registration District No. **3**

Primary Registration District No. **4167**

Registrar's No. **67**

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

1. PLACE OF DEATH:

(a) County **Dade**
(b) City or town **Greenfield, mo**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Smith rest Home 4
(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 **Ananda Graham**

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

4. Sex **F** / 5. Color or race **w**
6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Dellar Graham**
6. (c) Age of husband or wife if alive **76** years
7. Birth date of deceased **March 5 1880**
(Month) (Day) (Year)

8. AGE: Years **67** Months **3** Days **19** If less than one day hr. _____ min. _____

9. Birthplace **Dade Co** (City, town, or county) (State or foreign country) **MO**

10. Usual occupation **house wife**

11. Industry or business
MOTHER { 12. Name **Jim Haigh** 7
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name **Willis**
15. Birthplace _____ (City, town, or county) (State or foreign country) 9

16. (a) Informant **Dellar Graham**
(b) Address **Greenfield, mo**
17. (a) **Antioch** (b) Date thereof **July 27 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Antioch cemetery**
18. (a) Signature of funeral director **W. R. Allison**
(b) Address **Greenfield, mo**
19. (a) **7-25-47** (b) **W. R. Allison**
(Date received local registrar) (Registrar's signature) **7/27**

2. USUAL RESIDENCE OF DECEASED:

(a) State **mo** (b) County **Dade** 29
(c) City or town **Greenfield mo** 1
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) 0
(e) Citizen of foreign country? **no** (Yes or No) 0
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **July** day **27**
year **1947** hour **11** minute **30** P. M.

21. I hereby certify that I attended the deceased from **July 28**, 1947, to **July 28**, 1947,
that I last saw her alive on **July 27**, 1947,
and that death occurred on the date and hour stated above.

Immediate cause of death **gnyo cerebral failure (acute)** Duration _____

Due to _____
Due to _____

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

Major findings: Of operations **gyno P**
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 **Dr. Hal B. Jones** (Physician, coroner, or other) **20**
Address **Greenfield, mo** Date signed **7/27/47**

RECEIVED
District Health Officer No. 6;
District File Number 847-828
Date Filed AUG 12 1947

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 W. R. Allison

Licensed Embalmer No. 4404

P. O. Address Greenfield, Mo

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.