

No. 300
10-48
31
0

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7503

FILED FEB 17 1954
BIRTH NO. REG. DIST. NO. 340 PRIMARY REG. DIST. NO. 65-2 Registrar's No. 20

1. PLACE OF DEATH a. COUNTY Stoddard		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Dunklin	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Dexter Liberty		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Malden	
c. LENGTH OF STAY (in this place) weeks		0351	
d. FULL NAME OF HOSPITAL OR INSTITUTION Dr. Davis Hosp.		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print)	a. (First) Elzora	b. (Middle) Mae	c. (Last) Graham	4. DATE OF DEATH (Month) (Day) (Year)	Jan 23, 1954
-------------------------------------	-------------------	-----------------	------------------	---------------------------------------	--------------

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH April 10, 1872	9. AGE (In years last birthday) 81	IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Days	IF UNDER 2 HRS. Hours	IF UNDER 2 HRS. Min.
---------------	------------------------	--	---------------------------------	------------------------------------	------------------------	----------------------	-----------------------	----------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Ind.	12. CITIZEN OF WHAT COUNTRY? U.S.
---	-----------------------------------	--	-----------------------------------

13a. FATHER'S NAME T. J. Guthrie	13b. MOTHER'S MAIDEN NAME Martha Smith	14. NAME OF HUSBAND OR WIFE Samuel Graham
----------------------------------	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Ernest Craig	ADDRESS Malden Mo
---	------------------------------	--	-------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 6 mos
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Malnutrition		
ANTECEDENT CAUSES		DUE TO (b) Multiple Arteriosclerosis	
		DUE TO (c) and refusal to take medication	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	----------------------------------	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
--	--	----------------------------

22. I hereby certify that I attended the deceased from Nov 1, 1953, to Jan 23, 1954, that I last saw the deceased alive on Jan 23, 1954, and that death occurred at 2:45 P.M., from the causes and on the date stated above.

23a. SIGNATURE S.S. Pans	(Degree or title) M.D.	23b. ADDRESS Dexter Mo	23c. DATE SIGNED Jan 31, 1954
--------------------------	------------------------	------------------------	-------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Buried	24b. DATE Jan. 25, 1954	24c. NAME OF CEMETERY OR CREMATORY Park Cemetery	24d. LOCATION (City, town, or county) (State) Malden Mo
--	-------------------------	--	---

DATE REC'D BY LOCAL REG. 2-8-54	REGISTRAR'S SIGNATURE Helma V. Jamborek	519	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Irby Funeral Home Rector Ark
---------------------------------	---	-----	---

(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed.....

Don W. McQuisla

Licensed Embalmer No. 776

P. O. Address Rector 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.