

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

PLACE OF DEATH  
County Howell  
Township Long Creek or Village \_\_\_\_\_  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 387 File No. 4612  
Primary Registration District No. 55710 Registered No. 2

FULL NAME Arnon Graham

[If death occurred in a hospital or institution, give its NAME instead of street and number]

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Widower  
(Write the word)

DATE OF BIRTH Nov 10, 1848  
(Month) (Day) (Year)

AGE 76 yrs. 2 mos. 27 ds. If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Retired Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

DATE OF DEATH Feb 6, 1915  
(Month) (Day) (Year)

BIRTHPLACE (City or town, State or foreign country) Mo

PARENTS  
NAME OF FATHER Lewis Graham  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo  
MAIDEN NAME OF MOTHER Mary UK  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) UK

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_, that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_, and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH\* was as follows:  
Heart Failure

2.00A  
(Duration) yrs. mos. ds.

Contributory (SECONDARY) \_\_\_\_\_ (Duration) yrs. mos. ds.  
(Signed) W. H. Cunningham M. D.  
Feb 7, 1915 (Address) Howell, Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Henry Graham  
(ADDRESS) Olden, Mo

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds. In the State \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.  
Where was disease contracted if not at place of death? \_\_\_\_\_  
Former or usual residence \_\_\_\_\_

Filed Feb 7, 1915 Mattie DeValle  
REGISTRAR

PLACE OF BURIAL OR REMOVAL W. H. Jones Cemetery DATE OF BURIAL Feb 7, 1915  
UNDERTAKER None ADDRESS \_\_\_\_\_

N. B.—Every item of information should be carefully submitted. Example of OCCUPATION is very important. FULLY. PHYSICIANS should state

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health  
Association]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc. of ..... (name origin; "Cancer" is less definite; avoid

use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATED UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

PLACE OF DEATH

County Howell  
Township Big Creek  
or  
Village  
or  
City (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 387 File No. \_\_\_\_\_  
Primary Registration District No. 5540 Registered No. 2

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME

Carroll Graham

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX M COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED W  
(Write the word)

DATE OF DEATH Feb 6, 1915  
(Month) (Day) (Year)

DATE OF BIRTH \_\_\_\_\_, \_\_\_\_\_, 1\_\_\_\_\_  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_,  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_,  
and that death occurred, on the date stated above, at \_\_\_\_\_ m.

AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

The CAUSE OF DEATH\* was as follows:

OCCUPATION (a) Trade, profession, or particular kind of work \_\_\_\_\_  
(b) General nature of industry, business, or establishment in which employed, (or employer) \_\_\_\_\_

Heart Failure  
(cont'nou)

BIRTHPLACE (City or town, State or foreign country) \_\_\_\_\_

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

NAME OF FATHER \_\_\_\_\_

Contributory (SECONDARY) (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

BIRTHPLACE OF FATHER (City or town, State or foreign country) \_\_\_\_\_

(Signed) W. J. [unclear] M. D.  
\_\_\_\_\_ 1915 (Address) \_\_\_\_\_

MAIDEN NAME OF MOTHER: \_\_\_\_\_

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

BIRTHPLACE OF MOTHER (City or town, State or foreign country) \_\_\_\_\_

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) \_\_\_\_\_

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(ADDRESS) \_\_\_\_\_

Where was disease contracted if not at place of death? \_\_\_\_\_

Filed 2/7 1915 M. J. Mottet Registrar

Former or usual residence \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 191\_\_\_\_

UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

CAUSE OF DEATH in plain terms. If the cause of death is not stated EXACTLY, it shall be stated EXACTLY as far as possible. AGE shall be stated EXACTLY as far as possible. OCCUPATION is very important.

Supplementary Informant's Affidavit

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4612