MAR 26 1927

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

Do not use this space.
DT C-45578

1. PLACE OF DEATH
County: Ponnsent Registration District No.: 651
Township: Carutherville Primary Registration District No.: 4388
City: ..... (No. ..... St. ..... Ward)

File No. .....
Registered No. 23

2. FULL NAME: Mattie Graham
(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Black
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Clonne Graham

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Dont Know

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About 25				

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (CITY OR TOWN): Marion
(STATE OR COUNTRY): Ark.

PARENTS
10. NAME OF FATHER: Tom Jefferson
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Dont Know
(STATE OR COUNTRY): .....
12. MAIDEN NAME OF MOTHER: " "
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): "
(STATE OR COUNTRY): "

14. INFORMANT: Clarence Graham
(Address): Carutherville Mo

15. FILED: Feb. 14 1927 Ida Martin
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 2-14 1927

17. I HEREBY CERTIFY, That I attended deceased from Once on Feb 13, 1927, to ....., 19..., that I last saw h..... alive on ....., 19..., and that death occurred, on the date stated above, at 5-45 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Broncho-Pneumonia
10 Da
127 C
14 HB
(duration) yrs. 2 mos. 0 ds.

CONTRIBUTORY (SECONDARY): Exposure, Check of menses (duration) yrs. 2 mos. 0 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No! DATE OF .....
WAS THERE AN AUTOPSY? No!
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) Jacob M. Cockfield M. D
Feb. 14, 1927 (Address) Carutherville, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Mason Cemetery	2-14 1927
20. UNDERTAKER	**ADDRESS**
H S Smith	Cuble Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.