

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

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis** (No. **St. Johns Hospital**) St. _____ Ward _____

32072

File No. _____
 Registered No. **9445**

2. FULL NAME ELIZABETH GRAHAM

(a) Residence, No. 6111 Southwest Ave St. 2 Ward. _____
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female **4. COLOR OR RACE** White. **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Married.

5A. If MARRIED, WIDOWED, OR DIVORCED
 HUSBAND OF
 (or) WIFE OF

Wife of (H.M. Graham)

6. DATE OF BIRTH (MONTH, DAY AND YEAR) January 25 1868

7. AGE	YEARS	MONTHS	DAY	If LESS than 1 day, hrs. or min.
<u>59.</u>	<u>8.</u>	<u>28</u>		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Wife
 (b) General nature of industry, business, or establishment in which employed (or employer) At Home
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____
 (STATE OR COUNTRY) Minnesota

10. NAME OF FATHER Thomas J. Waite

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Pennsylvania

12. MAIDEN NAME OF MOTHER Mary Cochran

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Pennsylvania.

14. INFORMANT H.M. Graham
 (Address) 6111 Southwest Ave.

15. FILED OCT 24 1927 Max C. Starckoff
 19____ REGISTAR

MEDICAL CERTIFICATE OF DEATH

3
16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-23-1927

17. I HEREBY CERTIFY, That I attended deceased from 9-29, 1927, to 10-23, 1927, that I last saw h. alive on 10-23, 1927, and that death occurred, on the date stated above, at 8- P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebrosus following
an abdominal operation
48
99A (duration) _____ yrs. _____ mos. _____ da.
CONTRIBUTORY (SECONDARY) Operation carcinoma of
uterus (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____
1 DID AN OPERATION PRECEDE DEATH? ye DATE OF Sept 30-27
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Robt. Hyland
 (Signed) _____ M. D.
10/24-1927 (Address) 3901 Park Ave

*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 New St Marcus Semetary **DATE OF BURIAL** Oct 25 1927.

20. UNDERTAKER A.W. McLaughlin **ADDRESS** 1631 Mission

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.

