

**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. Baptist Hospital) St. Ward)

43022

File No.
 Registered No. **12297**

2. FULL NAME

Kate M Graves Pass
 (a) Residence, No. 5861 Plymouth Ave. St., 5 Ward. (If nonresident, give city or town and State)
 (Usual place of abode)
 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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>H. B. Pass</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>2-16-1846</u>		
7. AGE	YEARS <u>82</u>	MONTHS <u>10</u>
	DAY <u>1</u>	IF LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <u>house wife</u> (b) General nature of industry, business, or establishment in which employed (or employer). <u>at home</u> (c) Name of employer		

9. BIRTHPLACE (CITY OR TOWN) <u>Saline Co.</u> (STATE OR COUNTRY) <u>Mo.</u>	
PARENTS	10. NAME OF FATHER <u>Benj. G. Graves</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Mo.</u> (STATE OR COUNTRY)
	12. MAIDEN NAME OF MOTHER <u>Leah F. Degrass</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Mo.</u> (STATE OR COUNTRY)

14. INFORMANT <u>Lillian Pass</u> (Address) <u>5861 Plymouth Ave. St.</u>
15. FILED <u>17</u> 19 <u>28</u> <u>Marcel Harkness</u> REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-17-1928

17. I HEREBY CERTIFY, That I attended deceased from 5th Sept., 1928, to the 16th, 1928, that I last saw h. alive on the 16th, 1928, and that death occurred, on the date stated above, at 7 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic myocarditis
930
99
102 about (duration) 7 yrs. mos. ds.
 CONTRIBUTORY Arterial Hypertension r
 (SECONDARY) Arterial Sclerosis severe
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? No. DATE OF

20. WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS Clinical
 (Signed) Edward Street, M. D.

Dec 17th 1928 (Address) 3720 Washington 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 <u>Marshall Mo.</u>	DATE OF BURIAL <u>Dec. 18 1928</u>
20. UNDERTAKER <u>Alexander & Sons</u>	ADDRESS <u>6175 Dehu</u>

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

3720 *Muslinjth*