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.

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

Do not use this space.

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1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St. Louis (No. 708 S. 4th St. ..... St. ..... Ward)

File No. .....

Registered No. 5382

2. FULL NAME Michael Graney

(a) Residence. No. 708 S. 4th St. St., 22 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: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Single

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: ✓ ✓

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

7. AGE: Abt 67 YEARS | MONTHS: ✓ | DAYS: ✓ | If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Indiana

PARENTS

10. NAME OF FATHER: .....

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Unknown

12. MAIDEN NAME OF MOTHER: .....

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

14. INFORMANT: J. W. Kerner
(Address): Coroner's Office

15. FILED MAY 15 1929 Max C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 5/12/ 1929

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19..... that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 3 30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Asphyxiation Fuel Gas. (Self-administered) ..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Suicide ..... (duration) ..... yrs. ..... mos. ..... ds.

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

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) J. W. Kerner M. D.

5/15, 1929 (Address) Dep. Coroner

*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: Logansport Ind

DATE OF BURIAL: 5/16 1929

20. UNDERTAKER: Ziegenhein Bros.

ADDRESS: 2621 Cherokee St

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