

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

Do not use this space.

38850

**1. PLACE OF DEATH**

County..... Registration District No..... File No.....  
Township..... Primary Registration District No..... Registered No. **11292**  
City *St. Louis* (No. **ISOLATION HOSPITAL** St. **24th** Ward)

**2. FULL NAME**

*James Lee Graham alias Lee*  
(a) Residence No. *Atlantic Hotel* St. *25* Ward. (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 <i>Male</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Unknown</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>?</i>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>abt 1901</i>		
7. AGE YEARS <i>abt. 28</i>	MONTHS <i>? Unknown</i>	DAYS <i>?</i>
IF LESS than 1 day, ..... hrs. or ..... min.		
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <i>Laborer</i> (b) General nature of industry, business, or establishment in which employed (or employer)..... (c) Name of employer.....		
9. BIRTHPLACE (CITY OR TOWN)..... <i>Unknown</i> (STATE OR COUNTRY)		
PARENTS	10. NAME OF FATHER <i>Unknown</i>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... <i>Missouri</i> (STATE OR COUNTRY)	
	12. MAIDEN NAME OF MOTHER <i>Unknown</i>	
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... <i>Missouri</i> (STATE OR COUNTRY)	
14. INFORMANT..... <i>Lois Kroner</i> (Address) <i>ISOLATION HOSPITAL</i>		
15. FILED..... <i>19 1929 May 21</i> <i>Starkley</i> REGISTRAR		

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Nov 9 1929*

17. I HEREBY CERTIFY, That I attended deceased from *Nov 4*, 19*29*, to *Nov 9*, 19*29*, that I last saw him alive on *Nov 9*, 19*29*, and that death occurred, on the date stated above, at *5:45 P.M.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*Meningitis Pneumococci*  
*79 H*

(duration) ..... yrs. mos. *6* ds.

CONTRIBUTOR (SECONDARY) *71 W*  
(duration) ..... yrs. mos. .... ds.

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

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

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS  
(Signed) *W. H. Hubbel* M. D.  
*11-10 1929* (Address) *ISOLATION HOSPITAL*

\*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 <i>Interment in St. Louis</i>	DATE OF BURIAL <i>11-19-1929</i>
20. UNDERTAKER <i>John B. White</i>	ADDRESS <i>4800 General</i>

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.

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