

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

Do not use this space.

59414

APR 30 1930

1. PLACE OF DEATH

County Livingston
Township Green Ridge
City Chula (No. _____)

Registration District No. 589
Primary Registration District No. 5677

File No. _____
Registered No. 5 St. _____ Ward _____

2. FULL NAME William Orvell Graham

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. mos. da. How long in U. S., if of foreign birth? _____ yrs. mos. da. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Melba L. Graham</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>3-10-1859</u>		
7. AGE <u>70</u> YEARS	<u>11</u> MONTHS	<u>23</u> DAYS
If LESS than day, _____ hrs. or _____ min.		
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Farmer</u> (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) Ohio

PARENTS	10. NAME OF FATHER <u>James Graham</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Ohio</u>
	12. MAIDEN NAME OF MOTHER <u>Margaret Maguire</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Ohio</u>

14. INFORMANT Melba L. Graham
(Address) Chula mo

15. FILED 36 30 De Kroeyer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 6 1930

17. I HEREBY CERTIFY, That I attended deceased from Feb 6 1929 to Mar 6 1930 that I last saw him alive on Feb 16 1930, and that death occurred, on the date stated above, at _____ a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Endo-Carditis

18. WHERE WAS DISEASE CONTRACTED
92A Several (duration) _____ yrs. mos. da.
CONTRIBUTORY (SECONDARY) 900W (duration) _____ yrs. mos. da.

18. DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Physical Signs & Symptoms
(Signed) Respect Signed M. D.
3/6 1930 (Address) Chula 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 May Cemetery DATE OF BURIAL Mar 9 1930
20. UNDERTAKER McBort ADDRESS Chula 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.

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

