

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.

MAY 26 1930

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

Do not use this space.

12425

1. PLACE OF DEATH
 County Nath Registration District No. 392
 Township Bigelow Primary Registration District No. 1513
 City Bigelow (No.) St. Ward (....)

2. FULL NAME Addie L. Graham
 (a) Residence No. St. 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. 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 (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Richard Graham

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 1 1877

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>51</u>	<u>10</u>	<u>11</u>	

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

9. BIRTHPLACE (CITY OR TOWN) Bigelow, Mo.
 (STATE OR COUNTRY)

10. NAME OF FATHER Henry Jones

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Bigelow, Mo.
 (STATE OR COUNTRY) Ohio

12. MAIDEN NAME OF MOTHER Lucinda Green

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

14. INFORMANT Ralph Graham
 (Address) Ferriere Mo.

15. FILED 4/13/30 1930 J. L. Tracy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 17 1930

17. I HEREBY CERTIFY That I attended deceased from Dec 1927 to Apr 11 1930
 (that I last saw h. or alive on Apr 11 1930 and that death occurred, on the date stated above, at 10:30 p. m.)

THE CAUSE OF DEATH* WAS AS FOLLOWS:
carcinoma of uterus
46 53E
 (duration) 3 yrs. mos. da.

CONTRIBUTORY (SECONDARY) metastases in pelvic glands (duration) yrs. mos. da.

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

1 DID AN OPERATION PRECEDE DEATH yes DATE OF Dec 1927

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Chemical + operative
 (Signed) T. C. Hogan, M. D.
 (Address) Mound City 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 Mt Hope Cemetery DATE OF BURIAL 4/13 1930

20. UNDERTAKER M Crawford ADDRESS Mound City, Mo.

90-10-10

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
 County Dalt Registration District No. 372 File No. _____
 Township Bigelow Primary Registration District No. 35-19 Registered No. 665-
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Addie L. Graham
 (a) Residence. No. _____ St. _____ 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 1 - 1897

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
52 | 10 | 10

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work _____
 (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) _____

10. NAME OF FATHER _____

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

12. MAIDEN NAME OF MOTHER _____

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

14. INFORMANT _____
 (Address) _____

15. FILED 6-5-30 J. A. Tracy
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 11 - 1930

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him alive on _____, 19____, and that death occurred, on the date and above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH. _____
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) _____, M. D.
 _____, 19____ (Address)

*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 _____ DATE OF BURIAL _____
 _____ 19____

20. UNDERTAKER _____ ADDRESS _____

Every item of information should be carefully supplied. AG. CAUSE OF DEATH in plain terms, so that it may be properly classified. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

S-12423