

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

Do not use this space.

18138

CERTIFICATE OF DEATH

1. PLACE OF DEATH *St Louis Mullamphy Hospital* 781  
 County ..... Registration District No. *1002*  
 Township ..... Primary Registration District No. ....  
 City *St. Louis, Mo.* (No. *St. Louis Mullamphy Hospital* St. .... Ward) File No. ....  
 Registered No. *5296*

2. FULL NAME *Sister Blandina Graham*  
 (a) Residence. No. *St. Louis Mullamphy Hospital* St. *11* Ward. (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred *48* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Female</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Single</i>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>April 20, 1848</i>				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ..... hrs. or ..... min.
	<i>82</i>	<i>1<sup>st</sup></i>	<i>9</i>	
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <i>Religious</i> <i>59</i> (b) General nature of industry, business, or establishment in which employed (or employer) ..... (c) Name of employer .....				
9. BIRTHPLACE (CITY OR TOWN) <i>Boston</i> (STATE OR COUNTRY) <i>Mass.</i>				
PARENTS	10. NAME OF FATHER <i>Joseph McLean</i>			
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <i>Ireland</i> (STATE OR COUNTRY) .....			
	12. MAIDEN NAME OF MOTHER <i>Sara McKinnon</i>			
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <i>Ireland</i> (STATE OR COUNTRY) .....			
14.	INFORMANT <i>Sister Aloisine</i> (Address) <i>St. Louis Mullamphy Hospital</i>			
15.	MAY 30 1930 FILED <i>Max C. ...</i> REGISTRAR			

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *May 29* 19 *30*

17. I HEREBY CERTIFY, That I attended deceased from *June 1* 19 *27* to *May 29* 19 *30* that I last saw her alive on *May 29* 19 *30* and that death occurred, on the date stated above, at *8 P. M.*

THE CAUSE OF DEATH WAS AS FOLLOWS:  
*Diabetes Mellitus (Coma)*

*Diabetes Mellitus* (duration) *3* yrs. *3* mos. *3* ds.

CONTRIBUTORY (SECONDARY) *Arterio Sclerosis* (duration) *3* yrs. *3* mos. *3* ds.

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

19. DID AN OPERATION PRECEDE DEATH? *No* DATE OF .....  
 WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS? *Solubility*  
 (Signed) *E. O. ... M. D.*  
 19 *30* (Address) *Mass. ...*

\*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>Calvary</i>	DATE OF BURIAL <i>May 31 1930</i>
20. UNDERTAKER <i>Cullen Kelly</i>	ADDRESS <i>452 St. ... Boston</i>

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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