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

Do not use this space.

25060

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. 7256.

Township ..... Primary Registration District No. 1003 Registered No. 7256.

City St. Louis, Mo. (No. City Hospital #2 St. ..... Ward)

2. FULL NAME Baby Graves

(a) Residence. No. 116 @ 140 15th St., 25 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	Col	—

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 7-14-30

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
			1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St Louis
(STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER Lee Graves
11. BIRTHPLACE OF FATHER (CITY OR TOWN) —
(STATE OR COUNTRY) Louisiana
12. MAIDEN NAME OF MOTHER Lela McDonald
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) —
(STATE OR COUNTRY) Louisiana

14. INFORMANT A. Gertrude Creach
(Address) City Hospital #2

15. FILED JUL 21 1930, 19 Max C Harkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-15-1930

17. I HEREBY CERTIFY, That I attended deceased from 7-14-, 1930, to 7-15-, 1930 that I last saw her alive on 7-15-, 1930, and that death occurred, on the date stated above, at 9:55 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Premature - 1 mos

159 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 1610 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH —

DID AN OPERATION PRECEDE DEATH? No. DATE OF —

WAS THERE AN AUTOPSY? No —

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) J. E. Hampton, M. D.

7-17, 1930 (Address) City Hospital #2

*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
POTTERS FIELD	7-24-1930

20. UNDERTAKER	ADDRESS
E. Shannon, 1426 Carroll	

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.