

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

Do not use this space.

Graves
26549

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City *St. Louis* (No. **3351**)

Ward *Morgan*

File No.

Registered No. **7702**

St. Ward)

2. FULL NAME

(a) Residence. No. **3351 Morgan** St. **21** Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **19** yrs. **1** mos. **—** ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *Colored* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Widowed*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *unknown*

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
about 72 — —

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. *Home-Work*
(b) General nature of industry, business, or establishment in which employed (or employer). *Private Families*
(c) Name of employer *unknown*

9. BIRTHPLACE (CITY OR TOWN) *Osceola*
(STATE OR COUNTRY) *Arkansas*

10. NAME OF FATHER *Samuel Graves*

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

12. MAIDEN NAME OF MOTHER *Marguerite Graves*

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

14. INFORMANT *William Wright*
(Address) *3351 Morgan*

15. FILED *11 30 31* *Max O. Stewart* REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *7/4* 19*31*

17. I HEREBY CERTIFY, That I attended deceased from *6/30* 19*31* to *7/4* 19*31* that I last saw him alive on *7/3* 19*31*, and that death occurred, on the date stated above, at *9:45 A.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*Heart prostration 92A
Crown Aneurysm 45B
Aneurysm of heart, dis. 481*

CONTRIBUTORY (SECONDARY) *with hypertension 21* 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 *Physical Examination*
(Signed) *J. P. ...* M. D.
(Address) *20389 ...*

*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 *Washington Park.* DATE OF BURIAL *7/12/1931*

20. UNDERTAKER *Peoples Und. Co.* ADDRESS *3100 Franklin*

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.

