

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

Do not use this space.

4070

1. PLACE OF DEATH

County Registration District No. **701**
Township Primary Registration District No. **1000**
City **St. Louis** (No. **Christian Hospital**)

File No.
Registered No. **1038** St. Ward)

2. FULL NAME

(a) Residence, No. **Jasper J. Graves** St. **9** Ward. **Terre Haute Mo.**
(Usual place of abode)

Length of residence in city or town where death occurred yrs. **3** mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 15, 1930		
7. AGE	YEARS 2	MONTHS 8
	DAYS 14	If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____	
	10. Date deceased last worked at this occupation (month and year) _____	11. Total time (years) spent in this occupation _____
MOTHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Laurel Mississippi	
FATHER	13. NAME Paish Graves	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Georgia	
	15. MAIDEN NAME Emma Träteline	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Chicago Heights Illinois	
	17. INFORMANT Mrs Emma Graves (ADDRESS) 57 W. 23rd St. - Chicago 4th	
	18. BURIAL, CREMATION, OR REMOVAL PLACE Chicago 4th Ill. DATE Jan 30 19 33	
	19. UNDERTAKER Shepard Funeral Home (ADDRESS) 2167-69 Hamilton Ave.	
	20. FILED JAN 30 1933 Max C. [Signature] Registrar.	

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Jan 29, 1933**

22. I HEREBY CERTIFY, that I attended deceased from **January 1, 1933**, to **January 29, 1933**
I last saw h.t.m. alive on **January 28, 1933** Death is said to have occurred on the date stated above, at **8:40 A.M.**
The principal cause of death and related causes of importance were as follows:
Lobar pneumonia left Date of onset **1-13-33**
Secondary lobar pneumonia right **1-20-33**
Chills Malaria bilateral **1-1-33**

Name of operation Date of
What test confirmed diagnosis? **ye** Was there an autopsy? **no**

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19.....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify **Secondary lobar pneumonia**
(Signed) **[Signature]** M. D.
(Address) **718 Beaumont St. St. Louis 3720 Washington**

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

