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

Do not use this space.

42393

1. PLACE OF DEATH
County: Warren
Township: Bridgeport
City: ..... (No. ..... St. ..... Ward)

Registration District No.: 681
Primary Registration District No.: 6172

File No.:
Registered No.: 34

2. FULL NAME: Lieutenant Graham Meade St. John

(a) Residence. No. ..... St., ... 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. 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)
Male	White	Married.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Grace P. St John

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Sept 20 - 1896

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
37	2	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Reg. Army Officer
(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): Memphis, Tenn.

PARENTS
10. NAME OF FATHER: Not known
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Not known
12. MAIDEN NAME OF MOTHER: Not known
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Not known

14. INFORMANT: Capt. Wm B. Wright
(Address): Kansas City, Mo.

15. FILED: Dec 18 1933 A. W. Welling REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 12/18 1933

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19..., that I last saw h... alive on ....., 19..., and that death occurred, on the date stated above, at 8/9 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Viewed by my Capacity of Coroner and there is no death due to Air Plane accident - Multiple injuries, (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): 214M (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) [illegible] M.D.
12/19, 1933 (Address) Wolfe Hotel Kansas 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: Arlington Nat'l Cem Va — DATE OF BURIAL: 12/20 1933

20. UNDERTAKER: Freeman Mortuary — ADDRESS: Kansas City Mo

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