

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.

FEB 16 1939 REC'D MAR 9 1939

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

7887  
 Do not use this space.

**1. PLACE OF DEATH**

(a) County Saint Louis Registration District No. 784  
 (b) Township Carsadale Primary Registration District No. 202 Registered No. 274  
 (c) City Jefferson Barracks (d) Street No. U. S. Veterans Adm. Facility St.  
 (e) Length of residence in city or town where death occurred Unkn. (If death occurred in Hospital or Institution, write its name instead of street and number)  
 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

**2. PRINT FULL NAME** Paul E. GRAHAM

(a) Residence, No. 650 St.  Steelville, Missouri.  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF Mrs. Yolanda Graham (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) January 12, 1908

7. AGE YEARS 31 MONTHS 1 DAYS 2 If LESS than 1 day, .....hrs. or .....min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Soldier  
 9. Industry or business in which work was done, as saw mill, bank, etc. -  
 10. Date deceased last worked at this occupation (month and year) - 11. Total time (years) spent in this occupation -

12. BIRTHPLACE (CITY OR TOWN) Steelville, Missouri.

FATHER 13. NAME James Graham

14. BIRTHPLACE (CITY OR TOWN) Not known (STATE OR COUNTRY) Ohio.

MOTHER 15. MAIDEN NAME Isabelle Edwards

16. BIRTHPLACE (CITY OR TOWN) Not known (STATE OR COUNTRY) Missouri.

17. INFORMANT Clinch, Charles WAF., Jefferson Barracks, Missouri.

18. BURIAL, CREMATION, OR REMOVAL PLACE National Cemetery DATE February 18, 1939

19. FUNERAL DIRECTOR (NAME) C. Hoffmeister U. & L. Co (ADDRESS) 7814 S. B'way St. Louis, Mo.

20. FILED FEB 16 1939 Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) February 14, 1939

22. I HEREBY CERTIFY, That I attended deceased from January 3, 1939 to February 14, 1939

I last saw him alive on February 14, 1939. Death is said to have occurred on the date stated above, at 8:50A. m.

The principal cause of death and related causes of importance were as follows:

Tuberculosis, pulmonary, chronic, active, far-advanced (C). Date of onset Unkn.

Other contributory causes of importance: None

Name of physician None Date of NO  
 What test confirmed diagnosis? NO 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: Working for  
 (Signed) C. W. HUGHES, Chief Med. Officer D.  
 (Address) WAF., Jefferson Barracks, Mo.

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**