

No. 9-4
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

34988

FILED NOV 11 1942
Registration District No. 226

Primary Registration District No. 44821

State File No. _____

Registrar's No. 56

1. PLACE OF DEATH:

(a) County Scottsburg, Tenn

(b) City or town Memphis, Tenn
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community all here years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Scottsburg, Tenn

(c) City or town Memphis
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country NO

3. (a) PRINT FULL NAME Myrna Fay Graham

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 12 year 1942 hour 6 minute P M.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 28 1935
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Oct 1 1942 to Oct 1 1942 that I last saw her live on Oct 1 1942 and that death occurred on the date and hour stated above.

8. AGE: Years 4 Months 4 Days 4 If less than one day _____ hr. _____ min.

9. Birthplace Keokuk Ia
(City, town, or county) (State or foreign country)

Immediate cause of death Burned to death

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

11. Industry or business _____

12. Name Ernie Graham

13. Birthplace Lurray, MO
(City, town, or county) (State or foreign country)

14. Maiden name Ethel Wade

15. Birthplace Keokuk Ia
(City, town, or county) (State or foreign country)

Major findings: Of operations _____ Of autopsy _____

PHYSICIAN _____ Underline the cause to which death should be charged statistically.

16. (a) Informant Ernie Graham

(b) Address Memphis, Tenn

17. (a) Burial (b) Date thereof Oct 2-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lurray Cemetery

18. (a) Signature of funeral director W. B. Baker

(b) Address Memphis, Tenn

19. (a) Oct. 10 1942 (b) Bernice Wilson
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following: 099

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury ✓

23. Signature W. B. Baker (M. D. or other) _____

Address Memphis, Tenn Date signed 10/14/42

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

39
0

Handwritten scribbles at top left of page.

RECEIVED

District Health Officer No. 10

District File Number 11-42-1994

Date Filed NOV - 9 1942

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 *Fred G. Cook*

Licensed Embalmer No. 1029

P. O. Address Memphis

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

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 34983

Registration District No. 326 Primary Registration District No. 4482 Registrar's No. _____

1. PLACE OF DEATH:
(a) County Scotland
(b) City or town Memphis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days.

3. (a) PRINT FULL NAME Myrna Fay Gahan
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 28 1923
(Month) (Day) (Year)

8. AGE: Years 4 Months 4 Days _____ If less than one day _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry of business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ Day _____ Year 1942 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____; that I saw him _____ live on _____ 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____
Due to symptoms to death when nurse
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)
Major findings: Of operations _____
Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically.
181-15

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature MA Gahan (M. D. or other) _____
Address Memphis mo Date signed 12/14/42

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1942

S-34983