

FILED SEP 18 1944
318

Registration District No. _____ Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4651 Pope Ave.
(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 **Cozy Marie Graham**
3. (b) If veteran, name war _____ **3. (c) Social Security No.** _____

4. Sex **Female** **5. Color or race** **White** **6. (a) Single, widowed, married, divorced** **Married**
6. (b) Name of husband or wife **Frank W. Graham** **6. (c) Age of husband or wife if alive** **55** years
7. Birth date of deceased **November 24 1888**
(Month) (Day) (Year)

8. AGE: Years **55** Months **9** Days **12** If less than one day _____ hr. _____ min.

9. Birthplace **Wellsberg W. Va.**
(City, town, or county) (State or foreign country)
10. Usual occupation **Housewife**

11. Industry or business _____
12. Name **Samuel Shreeve**
13. Birthplace **Ohio**
(City, town, or county) (State or foreign country)
14. Maiden name **Micha Springborn**
15. Birthplace **W. Va.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Frank W. Graham**
(b) Address **4651 Pope Ave.**

17. (a) Burial **(b) Date thereof** **9/8/44**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Galvary Carroll**

18. (a) Signature of funeral director **Stroot-Carroll**
(b) Address **4600 Natural Bridge Ave.**

19. (a) SEP 7 1944 **(b) J. H. Bredebeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Doc**
(c) City or town **St. Louis** **1 1/2 9**
(If outside city or town limits, write "RURAL")
(d) Street No. **4651 Pope Ave.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Sept.** day **6**
year **1944** hour **3** minute **A** M.
21. I hereby certify that I attended the deceased from **Aug 24**
8th **1944** **to** **Sept 6 1944**
that I last saw her alive on **Sept 6** **1944**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage**
caused by rupture of
artery resulting in
slight perturbation of years
also mitral stenosis
Due to _____
Due to _____

Other conditions **9/2**
(Include pregnancy within 3 months of death)
Major findings:
Of operations **none**
Of autopsy **none**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **no**
(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 **Benjamin J. Murphy** (M. D. or other) **148**
Address **4232 W. F. Lewis** **Date signed** **9/6/44**

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 *Sheldon Collier*

Licensed Embalmer No. *3382*

P. O. Address.....

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.