

5-43
7-39
K36671

FILED OCT 4 1945

State File No. _____

Registration District No. 206

Primary Registration District No. 5751

Registrar's No. 58

1. PLACE OF DEATH:

(a) County Madison
(b) City or town Rural - - No. 34 St Michael
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Will - - Mrs
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Madison 6x
(c) City or town Rural 0
(If outside city or town limits, write "RURAL") 0
(d) Street No. Township No. 34 (If rural, give location) 0
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Harlen Gene Graham

(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Infant
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased May 27 1943
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
2 3 16 hr. min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name H. Cleveland Graham
13. Birthplace Madison County Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Edith Golden Dunn
15. Birthplace Unknown Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Cleveland Graham

(b) Address R#2, Fredericktown, Mo.

17. (a) Burial (b) Date thereof 9-15-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Madison Co., Mo.

18. (a) Signature of funeral director Stanley H. Dixon

(b) Address Fredericktown, Missouri

19. (a) 9-15-1945 (b) Florence Nichol
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September Day 13th
year 1945 hour 12:30 minute _____ P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him in a home on 9.13.45, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Colitis 10 days
Improper Diet

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death) 1200

Major findings: none

Of operations _____

Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence no

(c) Where did injury occur? no (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 no

Signature W. B. Bruner MD (M. D. or other)

Address Fredericktown, Madison Co. Date signed 9/15/45

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

RECEIVED

Director Health Officer No. 4
District File Number 1045-1135
Date Filed 10-2-45

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 Stanley H. Dixon

Licensed Embalmer No. 4193

P. O. Address Fredericktown, Mo.

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. octRegistration District No. 206Primary Registration District No. 5731Registrar's No. 58

1. PLACE OF DEATH:

(a) County Madison
(b) City or town Rural (St. Michael)
(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 _____ (Specify whether _____)
years, months or days3. (a) PRINT FULL NAME Harlan G. Graham

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased May 2 1945
(Month) (Day) (Year)8. AGE: Years 2 Months 3 Days _____ If less than one day
hr. _____ min.9. Birthplace _____ (City, town, or county) (State or foreign country) MO

10. Usual occupation _____

11. Industry or 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 _____
(Burial, cremation, or removal) (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 MO (b) County Madison
(c) City or town Rural
(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 5 Day _____
year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19 _____;

that I last saw him _____ alive on _____, 19 _____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

Due to _____

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 sta-
tistically.

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 _____ (M. D. or other)

Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

30959