

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
U.S. STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10246**
Registrar's No. **46**

Registration District No. **251**
Primary Registration District No. **3048**

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

1. PLACE OF DEATH: **Nodaway**

(a) County **Nodaway**

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

(c) Name of hospital or institution: **St. Francis Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **3 weeks**
(Specify whether years, months or days)

In this community **35 years**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Nodaway** **74**

(c) City or town **Maryville**
(If outside city or town limits, write "RURAL") **1/2**

(d) Street No. **3**
(If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country **A.**

3. (a) PRINT FULL NAME **John Graham**

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

MEDICAL CERTIFICATION

DATE OF DEATH: Month **March** day **10**
year **1946** hour **1** minute **20 P.** M.

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced, **widowed**

6. (b) Name of husband or wife **Mary Graham** 6. (c) Age of husband or wife if alive **years**

7. Birth date of deceased **May 16, 1861**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **March 10**, 19**46** to **March 10**, 19**46**

that I last saw him alive on **March 10**, 19**46** and that death occurred on the date and hour stated above.

Immediate cause of death: **Uremia**

8. AGE: Years **84** Months **9** Days **22**
If less than one day hr. min.

Due to **Ca of urinary bladder**
Generalized atrophic Sclerosis
Duodenal Sanitity

Other conditions: **None**
(Include pregnancy within 3 months of death)

9. Birthplace **Johnstown Pa.**
(City, town, or county) (State or foreign country)

10. Usual occupation **retired farmer**

Major findings: Of operations **526**

Of autopsy **526**

PHYSICIAN **526**
Underline the cause to which death should be charged statistically.

11. Industry or business **Robert Graham**

12. Name **Wicklów Co, Ireland** **4**

13. Birthplace **Anna** **Ireese**
(City, town, or county) (State or foreign country)

14. Maiden name **Dublin Ireland** **4**

15. Birthplace **Mrs. C.J. Merrigan**
(City, town, or county) (State or foreign country)

16. (a) Informant **Maryville, Missouri**

(b) Address **burial** (b) Date thereof **3-13-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Patrick's Cemetery**

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? _____

18. (a) Signature of funeral director **Marie Funeral home**

(b) Address **Maryville mo**

19. (a) **3-15-46** (b) **Bess Holt**
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature **W.P. Fisher** (M. D. or other) _____

Address **Maryville** Date signed **3-12-46**

JUL 10 1961

DISTRICT HEALTH OFFICE
Cameron, Mo.

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..... *W. L. Gee*

Licensed Embalmer No. *2539*

P. O. Address: *Marionville, 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.