

7. S. No. 2
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ev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 24 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13964

Registration District No. 178 Primary Registration District No. 3033 Registrar's No.

1. PLACE OF DEATH:
(a) County Laclede
(b) City or town Lebanon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Wallace Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 40 minutes
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Laclede 53
(c) City or town Phillipsburg 0
(If outside city or town limits, write "RURAL")
(d) Street No. Rural 0
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Judith Graves
3. (b) If veteran, name war..... 3. (c) Social Security No.....

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 12
year 1947 hour 7 minute 9 M.
21. I hereby certify that I attended the deceased from
4-12, 1947 to 4-12, 1947
that I last saw her alive on 4-12, 1947
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race W
6. (a) Single, widowed, married, divorced 0
6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased April 12 1947
(Month) (Day) (Year)

Immediate cause of death Premature birth
6 mo
Duration

8. AGE: Years Months Days If less than one day
hr. 40 min.

Due to.....
Due to.....
Other conditions (Include pregnancy within 3 months of death)

9. Birthplace Laclede Co. mo. 0
(City, town, or county) (State or foreign country)
10. Usual occupation.....

Major findings:
Of operations.....
Of autopsy.....
PHYSICIAN
Underline the cause to which death should be charged statistically.

11. Industry or business.....
12. Name William Graves 0
13. Birthplace Webster Co. mo.
(City, town, or county) (State or foreign country)
14. Maiden name Anna Ward
15. Birthplace Laclede Co. mo. 0
(City, town, or county) (State or foreign country)

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?

16. (a) Informant William Graves
(b) Address Phillipsburg mo.
17. (a) Burial (b) Date thereof 4-13-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt Zion Cemetery
18. (a) Signature of funeral director No Funeral Director
(b) Address.....
19. (a) April 19, 1947 (b) Ch Frankberger
(Date received local registrar) (Registrar's signature)

23. Signature JW Lindsay (M. D. or other MD)
Address Conway Mo (Specify type of place) (e) Means of injury 0
While at work (Specify type of place) (e) Means of injury

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

MOTHER FATHER

Received 4/23/47
Laclede County Health Unit
File No. 4-47-61
Date Filed 4/23/47

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.....
No Embalming....., 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 comply with the above constitutes grounds for revocation of license.)

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