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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 11 1949

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7

Registration District No. 1 — Primary Registration District No. 3000 — Registrar's No. [redacted] 5

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

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Macon
(c) City or town: Atlanta (Rural) (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:

3. (a) PRINT FULL NAME: Sarah A. Graham
3. (b) If veteran, name war: no
3. (c) Social Security No.: none
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: E. B. Graham
6. (c) Age of husband or wife if alive: 70 years
7. Birth date of deceased: Feb. (Month) 25 (Day) 1896 (Year)
8. AGE: Years 52 | Months 10 | Days 6 | If less than one day: hr. min.
9. Birthplace: Sullivan Co Mo (City, town, or county) (State or foreign country)
10. Usual occupation: House wife
11. Industry or business:
MOTHER FATHER
12. Name: C. E. Arthurs
13. Birthplace: Ind. (City, town, or county) (State or foreign country)
14. Maiden name: Mable Bailey
15. Birthplace: Sullivan Co Mo (City, town, or county) (State or foreign country)
16. (a) Informant: E. B. Graham
(b) Address: Atlanta Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1-4-49 (Month) (Day) (Year)
(c) Place: burial or cremation: Mt Tabor
18. (a) Signature of funeral director: H M Goodwin
(b) Address: Atlanta Mo
19. (a) 1-2-49 (Date received local registrar) (b) Nate Lambert (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 2nd year 1949 hour 11 minute 20 A.M.
21. I hereby certify that I attended the deceased from January 1st 1949, to January 2, 1949 that I last saw her alive on January 2 1949 and that death occurred on the date and hour stated above.

Immediate cause of death: Acute Respiratory Failure — Duration
Due to: Cerebral Thrombosis
Due to:
Other conditions (Include pregnancy within 3 months of death):
Major findings: Of operations:
Of autopsy: 4 6 6

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):
(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? (Specify type of place)
While at work?
(e) Means of injury:
23. Signature: C. T. Rhoads (M. D. or other) D.O.
Address: Kirksville, Mo Date signed: 1-2-49

(Licensed Embalmer's Statement on Reverse Side)

VS DEC 8 1959

RECEIVED
District Health Officer No. 10
District File Number 1.49.47
Date Filed JAN 10 1949

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 H M Goodding

Licensed Embalmer No. 1750

P. O. Address Alameda Mo.

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

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