

FILED DEC 21 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40476

BIRTH NO. _____		REG. DIST. NO. <u>53</u>		PRIMARY REG. DIST. NO. <u>3011</u>		Registrar's No. <u>103</u>	
1. PLACE OF DEATH a. COUNTY <u>Carroll</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Carroll</u> c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Carrollton</u> d. STREET ADDRESS (If rural, give location) <u>1</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Carrollton</u>		c. LENGTH OF STAY (in this place) <u>2 hrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Carrollton</u>		d. STREET ADDRESS (If rural, give location) <u>1</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Staton Clinic</u>				d. STREET ADDRESS (If rural, give location) <u>0</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mable</u>		b. (Middle) <u>Marie</u>		c. (Last) <u>GRAHAM</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>NOV 27 1949</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>JAN 7, 1916</u>	
9. AGE (In years last birthday) <u>33</u>		IF UNDER 1 YEAR Months <u>10</u> Days <u>20</u>		IF UNDER 4 HRS. Hours <u>0</u> Min. <u>0</u>		11. BIRTHPLACE (State or foreign country) <u>Mo</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY _____		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Seth Scott</u>			13b. MOTHER'S MAIDEN NAME <u>Minnie Wilson</u>			14. NAME OF HUSBAND OR WIFE <u>Eugene Graham</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Eugene Graham</u> ADDRESS <u>Carrollton Mo</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		<p align="center">MEDICAL CERTIFICATION</p> <p>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Exsanguination few hrs.</u></p> <p>ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Ruptured blood vessel of placenta</u> DUE TO (c) <u>(AT Home)</u></p> <p>II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>670X</u></p>					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____		21f. HOW DID INJURY OCCUR? _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>Nov. 27, 1949</u> , to <u>Nov 27, 1949</u> , that I last saw the deceased alive on <u>Nov. 27, 1949</u> , and that death occurred at <u>3:15 p.m.</u> from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>H. Hamilton Staton, M.D., Carrollton, Mo.</u>				23b. ADDRESS <u>Carrollton, Mo.</u>		23c. DATE SIGNED <u>Nov. 27, 1949</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>NOV 29, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Plain View</u>		24d. LOCATION (City, town, or county) (State) <u>CHULA Mo</u>	
DATE REC'D BY LOCAL REG. <u>9/29/49</u>		REGISTRAR'S SIGNATURE <u>Mr. Herbert Calvert</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>E.A. Dickerson</u>		ADDRESS <u>Bagard Mo</u>	

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

DEC 12

RECORDED

District Health Officer No. 2

JAN 17 1950

MAR 23 1950

12-20-49

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed E. A. Dickerson.....

Licensed Embalmer No. 2534.....

P. O. Address Bozard, 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.