

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **10009**

MAR 29 1952

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **2264**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Jefferson</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>ST. LOUIS MISSOURI</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>DeSoto 0502</b>	
c. LENGTH OF STAY (In this place) <b>16 day.</b>		d. STREET ADDRESS (If rural, give location) <b>508 Boyd St.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>NANCY</b> b. (Middle) <b>NMN</b> c. (Last) <b>GRAHAM</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>MARCH 8 1952</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>never Married</b>	8. DATE OF BIRTH <b>Aug. 25, 1879</b>
9. AGE (In years) (Months) (Days) (Hours) (Min.) <b>72</b>		11. BIRTHPLACE (State or foreign country) <b>Cedar Hill, Mo.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		13a. FATHER'S NAME <b>Lafayette Graham</b>	
13b. MOTHER'S MAIDEN NAME <b>Elizabeth Hilterbrand</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Edward Graham, DeSoto, Mo.</b>			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Bronchopneumonia</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Heart failure</b> DUE TO (c) <b>Generalized arteriosclerosis</b> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>= ASHD</b>	
19a. DATE OF OPERATION <b>none</b>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" 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)	
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? <b>H200</b>			
22. I hereby certify that I attended the deceased from <b>FEB. 21</b> , 19 <b>52</b> , to <b>MARCH 8</b> , 19 <b>52</b> that I last saw the deceased alive on <b>MARCH 8</b> , 19 <b>52</b> , and that death occurred at <b>9:45 pm.</b> , from the causes and on the date stated above.			
23. SIGNATURE (Degree or title) <b>Lafayette Graham M.D.</b>		23b. ADDRESS <b>BARNES HOSPITAL</b>	
23c. DATE SIGNED <b>3/8/52</b>		24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	
24b. DATE <b>3-9-52</b>		24c. NAME OF CEMETERY OR CREMATORY <b>City</b>	
24d. LOCATION (City, town, or county) (State) <b>Hematite, Mo.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Albert H. Hoppe, 4700 Washington Blvd.</b>	
DATE REC'D BY LOCAL <b>MAR 10 1952</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b> <b>MGB.</b> (Licensed Embalmer's Statement on Reverse Side)	

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

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 \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed *John L. Kennealy*  
Student Embalmer No. \_\_\_\_\_  
Licensed Embalmer No. *4194*

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.