

U.S. DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041548

FILED VS DEC 12 1960

Registration District No. 115-116 Primary Registration District No. 3020 Registrar's No. 267

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <i>Franklin</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY <i>Franklin</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <i>Washington</i>	Length of stay in 1b <i>33 yrs.</i>	c. CITY OR TOWN <i>Washington</i>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>St. Francis Hosp.</i>		d. STREET ADDRESS (If outside, give location) <i>417 E. Third</i>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <i>William Preston Graham</i>			4. DATE OF DEATH Month Day Year <i>Dec. 6, 1960</i>		
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>5/30/1881</i>	9. AGE (last birthday) <i>79</i>	IF UNDER 1 YEAR IF UNDER 24 HR Months Day Hours Min. <i>6 6</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Barber</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Barber</i>	11. BIRTHPLACE (City and state or country) <i>Marion Co., Missouri</i>	12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13a. FATHER'S NAME <i>Michael S. Graham</i>		13b. MOTHER'S MAIDEN NAME <i>Amanda Eads</i>	14. NAME OF HUSBAND OR WIFE <i>Nonnie Graham</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>494-38-0386</i>	17. INFORMANT <i>Alfred H. Graham, Washington, Mo</i>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *arteriosclerotic cardiovascular disease - fractured coronary artery*

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  
DUE TO (b) *no distinct gross cause?*

DUE TO (c) *no distinct gross cause?*

INTERVAL BETWEEN ONSET AND DEATH  
*10 yrs?*

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)  
*death found at autopsy*

PART III. If deceased was female was there a pregnancy in last 90 days.  
 Yes  No  Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	20b. SUICIDE <input type="checkbox"/>	20c. HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE

21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_.  
Death occurred at *12:45 P.M.* on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Dr. Charles Paul Leonard Union Pro</i>	22b. ADDRESS	22c. DATE SIGNED <i>12/6/60</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <i>Dec 9, 1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Crismon Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Vienna, Missouri</i>
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24. FUNERAL DIRECTOR <i>Hebert W. Witt, Inc., Washington, Mo</i>	25. DATE RECD. BY LOCAL REG. <i>12/7/60</i>	26. REGISTRAR'S SIGNATURE <i>F. L. Hickman &amp; G. H. Hickman</i>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NO DEC 20 1960

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Lester A. Witt

Licensed Embalmer No. 3254

P. O. Address Washington

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.