

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-029303**  
STATE FILE NUMBER

Registration District No. 239 Primary Registration District No. 4356 Registrar's No. 32

DO NOT WRITE ON THIS STUB  
AMENDED

<b>FILED AUG 6 1963</b>			
<p><b>1. PLACE OF DEATH</b></p> <p>a. COUNTY <u>New Madrid</u></p> <p>b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Parma</u> Length of stay in lb <u>3 yrs</u></p> <p>c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>family home</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p><b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Missouri</u> COUNTY <u>New Madrid</u></p> <p>c. CITY OR TOWN <u>Parma</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS <u>home</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>		
<p><b>3. NAME OF DECEASED</b> (Type or print) First <u>Benjamin</u> Middle <u>Franklin</u> Last <u>Graham</u></p>			
<p><b>4. DATE OF DEATH</b> Month <u>July</u> Day <u>30</u> Year <u>1963</u></p>			
<p><b>5. SEX</b> <u>male</u></p>	<p><b>6. COLOR OR RACE</b> <u>cauc.</u></p>	<p><b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p>	<p><b>8. DATE OF BIRTH</b> <u>6/19/1890</u></p>
<p><b>10a. USUAL OCCUPATION</b> (Give kind of work done or occupation if retired) <u>Retired trucker</u></p>		<p><b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>trucking</u></p>	
<p><b>11. BIRTHPLACE</b> (City and state or country) <u>Charleston, Mo</u></p>		<p><b>12. CITIZEN OF WHAT COUNTRY</b> <u>U. S.</u></p>	
<p><b>13a. FATHER'S NAME</b> <u>Marion Graham</u></p>		<p><b>13b. MOTHER'S MAIDEN NAME</b> <u>Martha Billings</u></p>	
<p><b>14. NAME OF HUSBAND OR WIFE</b> <u>Ada Graham</u></p>		<p><b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes or unknown) <u>WW I</u> (If yes, give war or dates of service)</p>	
<p><b>17. INFORMANT</b> <u>Imogene Tolle, St. Louis, MO</u> Address</p>			<p><b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)</p>
<p><b>PART I. DEATH WAS CAUSED BY:</b></p> <p>IMMEDIATE CAUSE (a) <u>Myocardial infarction</u></p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____</p>			<p>INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u></p>
<p><b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH</b> but not related to the terminal disease condition given in PART I (a)</p>			<p><b>PART III. If deceased was female was there a pregnancy in last 90 days.</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>
<p><b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>		<p><b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/></p>	
<p><b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)</p>			
<p><b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____</p>		<p><b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/></p>	
<p><b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>was D.O.A. at clinic</u></p>		<p><b>20f. CITY, TOWN, OR LOCATION</b> _____ COUNTY _____ STATE _____</p>	
<p><b>21. I attended the deceased from _____ and last saw her alive on _____</b> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.</p>			
<p><b>22a. SIGNATURE</b> (Degree or title) <u>Wm E. Morehead, M.D.</u></p>		<p><b>22b. ADDRESS</b> <u>Walden Mo</u></p>	
<p><b>22c. DATE SIGNED</b> <u>8/1/63</u></p>		<p><b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Lakewood park Cem.</u></p>	
<p><b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>burial</u></p>		<p><b>23b. DATE</b> <u>8/2/1963</u></p>	
<p><b>23d. LOCATION</b> (City, town, or county) <u>St. Louis, MO</u></p>		<p><b>24. FUNERAL DIRECTOR</b> <u>Watkins &amp; Sons Parma, MO</u> ADDRESS _____</p>	
<p><b>25. DATE RECD. BY LOCAL REG.</b> <u>8-1-1963</u></p>		<p><b>26. REGISTRAR'S SIGNATURE</b> <u>Charles Simpson by H. L. Ponder</u></p>	

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

AUG 9 1963

AUG 30 1963

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

Signed Marsh Wetheris

Licensed Embalmer No. 4717

P. O. Address Dexter 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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