

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

2725

1. PLACE OF DEATH

County Henry
 Township White oak
 City Union mo (No.)

Registration District No. 347
 Primary Registration District No. 5495

File No.
 Registered No.
 St. Ward

2. FULL NAME

Charles Leased Graham

(a) Residence, No. Henry co mo St. Rural Ward

Length of residence in city or town where death occurred 68 yrs. 10 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) 1

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 2 1872

7. AGE YEARS MONTHS DAYS IF LESS than 1 day; hrs. or min.
68 10 15

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Insurance Agent
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Agent
 10. Date deceased last worked at this occupation (month and year) Dec 3 1940
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Union co Ky

13. NAME J. L. Graham

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

15. MAIDEN NAME Irene Brooks

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

17. INFORMANT Mrs C. L. Graham (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Union mo DATE Jan 3 1941

19. UNDERTAKER W. J. Brown (ADDRESS)

20. FILED Jan 3 1941 J. R. Hampton Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 1 1941

22. I HEREBY CERTIFY, That I attended deceased from 7:45 pm Jan 1, 1941 to 10:30 pm Jan 1, 1941
 I last saw him alive on Jan 1, 1940 Death is said to have occurred on the date stated above, at 10:15 pm.

The principal cause of death and related causes of importance were as follows:

Cornary thrombosis Date of onset

Other contributory causes of importance: 94 W

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury , 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Dr. E. Briggs, Jr.

(Address) Union Missouri

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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1. PLACE OF DEATH

County..... Registration District No..... File No.....
Township..... Primary Registration District No..... Registered No.....
City..... (No.....)..... St..... Ward.....

2. FULL NAME.....

(a) Residence, No..... St..... Ward.....
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (<i>write the word</i>)		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)				
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day,hrs. ormin.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.....		11. Total time (years) spent in this occupation.....	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.....			
	10. Date deceased last worked at this occupation (month and year).....			
12. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)				
FATHER	13. NAME			
	14. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)			
MOTHER	15. MAIDEN NAME			
	16. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)			
17. INFORMANT (ADDRESS)				
18. BURIAL, CREMATION, OR REMOVAL				
PLACE..... DATE..... 19.....				
19. UNDERTAKER (ADDRESS)				
20. FILED..... 19.....				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR)....., 19.....

22. I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19.....
I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at.....m.
The principal cause of death and related causes of importance were as follows:
RECEIVED
District Health Officer No. 7
District File Number 2-41-272
Date Filed 2-7-41
Date of onset.....

Other contributory causes of importance:
.....
.....
.....

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury....., 19.....
Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....
If so, specify.....
(Signed)....., M. D.
(Address).....

Registrar.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.