

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

NVE 11 EDD 09 64

Primary Registration District No. 3042

Registrar's No.

0041268

STATE FILE NUMBER

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|---|---|--|---|
| 1. PLACE OF BIRTH a. COUNTY Madison | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Madison | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) Fredericktown | | c. CITY OR TOWN Arcadia | |
| Length of stay in 1b 1 1/2 days | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Madison Memorial Hospital | | d. STREET ADDRESS (If outside, give location) Route 1 | |
| Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Walter Scott Graham | | 4. DATE OF DEATH Nov. 3, 1964 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 9-17-1882 |
| 9. AGE (last birthday) 82 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 11. BIRTHPLACE (City and state or country) Salem, Mo. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME Emanuel Graham | | 13b. MOTHER'S MAIDEN NAME Victoria Golden | |
| 14. NAME OF HUSBAND OR WIFE Anna Graham | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Ralph Graham, Weingarten, Mo. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cerebral Thrombosis. | | INTERVAL BETWEEN ONSET AND DEATH 1 Day | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral Arteriosclerosis. | | years | |
| DUE TO (c) Generalized Arteriosclerosis. | | years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> 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 a.m. p.m. Month, Day, Year | | | |
| 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 Sept. 13, 1954 to Nov 3, 1964 and last saw him alive on Nov 2, 1964 Death occurred at 3:35 A m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE Charles E. Michaelis | | 22b. ADDRESS Fredericktown Missouri | |
| 22c. DATE SIGNED Nov 6, 64 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 11-5-1964 | 23c. NAME OF CEMETERY OR CREMATORY French Mills Cemetery | 23d. LOCATION (City, town, or county) (State) Madison County, MO. |
| 24. FUNERAL DIRECTOR Sam Najim, Jr. | | 25. DATE REC'D. BY LOCAL REG. 11-6-1964 | |
| ADDRESS 209 West Main St. Fredericktown, Mo. | | 26. REGISTRAR'S SIGNATURE Charles Boone, Jr. M.D. | |

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

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

Robert L. Seabaugh

Licensed Embalmer No.

5276

P. O. Address

Fredricktown 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.