

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

PLACE OF DEATH
County Cook
Township Marion
or
Village
or
City (NO. _____ St. _____ Ward _____)

Registration District No. 649 File No. 7405
Primary Registration District No. 5860 Registered No. _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Walter Graves

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE American SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)

DATE OF BIRTH Sep 25 1907
(Month) (Day) (Year)

AGE 3 yrs. 4 mos. 2 ds. IF LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 0

BIRTHPLACE (City or town, State or foreign country) Thomfield Mo

NAME OF FATHER Jack Graves

BIRTHPLACE OF FATHER (City or town, State or foreign country) Springfield Mo

MAIDEN NAME OF MOTHER Eddie Smith

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Thomfield Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W.C. Lewis

(ADDRESS) Noble Mo

Filed Feb 10 1911 G.R. Davis

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 25 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 15 1911, to Jan 25 1911, that I last saw him alive on Jan 24 1911, and that death occurred, on the date stated above, at 39 m.

The CAUSE OF DEATH* was as follows:

Erysipelas
15B

(Duration) _____ yrs. _____ mos. 10 ds.

Contributory (SECONDARY)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W.C. Lewis M. D.
Feb 10 1911 (Address) Noble Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted If not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Thomfield Mo DATE OF BURIAL Jan 26 1911

UNDERTAKER Neighbors ADDRESS Thomfield Mo

PLACE OF DEATH

County _____

Township _____
or _____Village _____
or _____

City _____ (NO. _____)

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

St. _____ Ward _____

[If death occurred in a
hospital or institution,
give its NAME instead
of street and number]

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____ COLOR OR RACE _____
SINGLE
MARRIED
WIDOWED
OR DIVORCED
(If wife the word)

DATE OF BIRTH _____

AGE _____ (Month) _____ (Day) _____ (Year) _____
IF LESS than
1 day, _____ hrs.
or _____ min.?OCCUPATION _____
(a) Trade, profession, or
particular kind of work _____
(b) General nature of industry,
business, or establishment in
which employed (or employer) _____BIRTHPLACE
(City or town,
State or foreign country) _____NAME OF
FATHER _____BIRTHPLACE
OF FATHER
(City or town, State or foreign country) _____MAIDEN NAME
OF MOTHER _____BIRTHPLACE
OF MOTHER
(City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____

191 _____

REGISTRAR _____

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____

_____, 191_____, (Month) _____, 191_____, (Day) _____, (Year) _____

I HEREBY CERTIFY, that I attended deceased from _____

_____, 191_____, to _____, 191_____,

that I last saw him alive on _____, 191_____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(SECONDARY)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____

_____, 191_____, (Address) _____ M. D.

*State the Disease Causing Death, or, in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR
RECENT RESIDENTS)At place of death, _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted
if not at place of death?Former or
usual residence _____

PLACE OF BURIAL OR REMOVAL _____

DATE OF BURIAL _____

UNDERTAKER _____

ADDRESS _____