WRITE PLAINLY, WITH UNFADING INK. [illegible]

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. See instructions on back of certificate.

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

PLACE OF DEATH

County Nodaway

Township ~~Nodaway~~ or Village or City Burlington Junc. Mo.

Registration District No. 618 File No. 18520a

Primary Registration District No. 4369 Registered No. 9

(NO. ..... St.: ..... Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Jonathan S. Graves

PERSONAL AND STATISTICAL PARTICULARS

SEX: Mal

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: Dec 18 (Month) (Day), 1842 (Year)

AGE: 68 yrs. 4 mos. 22 ds. If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): 1-02

BIRTHPLACE (City or town, State or foreign country): Vinton Co Ohio

PARENTS
NAME OF FATHER: Nathan B Graves
BIRTHPLACE OF FATHER (City or town, State or foreign country): N. C.
MAIDEN NAME OF MOTHER: Sarah Graves
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ohio

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sheridan Graves

(ADDRESS) Burl - Jct. Mo.

Filed May 12 1911. O. L. Dean REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: May (Month) 10 (Day), 1911 (Year)

I HEREBY CERTIFY, that I attended deceased from April 25th, 1911, to May 10, 1911, that I last saw him alive on May 10, 1911, and that death occurred, on the date stated above, at 4 P.m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism
8 V B

(Duration) 8 yrs. ..... mos. 7 ds.

Contributory (SECONDARY)

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

(Signed) O. L. Dean M. D.

May 12 1911 (Address) Burl - Jct. 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: Ohio Cemetery

DATE OF BURIAL: May 12, 1911

UNDERTAKER: T. E. Fordyce

ADDRESS: Burl Jc Mo

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

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....

or

Village ..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. ..... St.; ..... Ward)

[If death occurred i hospital or institut give its NAME inst of street and number]

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

..... (Month) ..... (Day), 1..... (Year)

AGE ..... yrs. ..... mos. ..... ds. 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)

PARENTS

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

..... (Month) ..... (Day), 191 (Ye

I HEREBY CERTIFY, that I attended deceased f

....., 191...., to ....., 191

that I last saw h..... alive on ....., 191

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

The CAUSE OF DEATH* was as follows:

.....

.....

..... (Duration) ..... yrs. ..... mos. .....

Contributory .....
(SECONDARY)

..... (Duration) ..... yrs. ..... mos. .....

(Signed) ..... M

....., 191.... (Address) .....

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

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

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

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191
UNDERTAKER	ADDRESS

[Approved by U. S. Census and American Public Health Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many

atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc. when a definite disease can be ascer-