

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

Do not use this space.

27194

**1. PLACE OF DEATH**

County Jackson Registration District No. 399

Township Kaw Primary Registration District No. 1002

City Kansas City (No. 238 W. 4th St.)

File No. \_\_\_\_\_

Registered No. 2152

St. \_\_\_\_\_ Ward) \_\_\_\_\_

**2. FULL NAME** Anna Mae Graves

(a) Residence. No. 238 W. 4th 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. 2 mos. \_\_\_\_\_ ds. How long in U.S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**PERSONAL AND STATISTICAL PARTICULARS.**

3. SEX Female 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF None

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 28, 1927

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min. 0 2 70

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work Infant (b) General nature of industry, business, or establishment in which employed (or employer) at home (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Kansas City (STATE OR COUNTRY) Mo

10. NAME OF FATHER Oscar Graves

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER Goldie Graves

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Mo

14. INFORMANT Oscar Graves (Address) 238 W. 4th St

15. FILED 9/8 27 M. M. Combe REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-5-19

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Bacterial pneumonia (primary)  
1074 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) 1000 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_ IF NOT AT PLACE OF DEATH? \_\_\_\_\_

8 DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

9 WAS THERE AN AUTOPSY? Y

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_ (Signed) [Signature] M. D.

19719 (Address) 1610 E. Deputy Com

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Blue Ridge DATE OF BURIAL Sept. 8, 19 27

20. UNDERTAKER Adkins Bros ADDRESS 2127 Vine

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.

