

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

Do not use this space.

1. PLACE OF DEATH

County Buchanan
Township _____
City St Joseph

Registration District No. 85
Primary Registration District No. 1001

File No. _____
Registered No. 351
St. _____ Ward _____

2. FULL NAME

(a) Residence No. _____ St. _____ Ward. Riviera
(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. 0 mos. 0 ds. How long in U.S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 23, 1890

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
38 4 19

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Kansas

10. NAME OF FATHER Robert McCall

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Unknown

14. INFORMANT George Graves
(Address) R.R. # 7 St Joseph

15. FILED 14 1929 John J. [Signature] REGISTRAR

3. MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 12 1929

17. I HEREBY CERTIFY, That I attended deceased from March 9, 1929, to March 12, 1929, that I last saw her alive on March 12, 1929, and that death occurred, on the date stated above, at 7:45 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cause of Crisis with ketonuria
Myocardial Insufficiency

(duration) _____ yrs. Several mos. _____ ds.

CONTRIBUTORY (SECONDARY) 40
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH St. Joseph, Mo.

DID AN OPERATION PRECEDE DEATH? yes DATE OF March 10

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Operation + clinical symptoms
(Signed) Carle [Signature], M. D.

Ind. 12, 1929 (Address) 731 Forum

*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

King Hill

DATE OF BURIAL

March 15 1929

20. UNDERTAKER

Fleeman Funeral Home 1208 Francis

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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