

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

Do not use this space.

708

1. PLACE OF DEATH

County Sumner
Township Salon
City Smith (No. _____) (St. _____ Ward)

Registration District No. 290
Primary Registration District No. 5408

File No. _____
Registered No. 5

2. FULL NAME

Ross E. Graves
(a) Residence. No. _____ 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. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 4 1927

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
2 4 16

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Heckory Ridge, Ark.

10. NAME OF FATHER R. J. Graves

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____

(STATE OR COUNTRY) Oden Ind.

12. MAIDEN NAME OF MOTHER Blain Havin

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____

(STATE OR COUNTRY) Malden, Minn.

14.

INFORMANT R. J. Graves
(Address) Smith Mo.

15.

FILED 2-1 1930 H. W. Beale REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 20 1930

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____, 7 9 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

The child died of acute indigestion
was dead when I arrived
(duration) _____ yrs. _____ mos. 1 ds.

CONTRIBUTORY (SECONDARY)

Was gassed on fresh pork.
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Robert E. Masten, M. D.

, 19 _____ (Address) Smith Mo.

*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

DATE OF BURIAL

Cedar Cemetery Jan 21 1930

20. UNDERTAKER

ADDRESS

W. H. Davis & Son Co Smith Mo.

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.

THIS IS A PERMANENT RECORD

18

8, 1930
 35
 9
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