

APR 30 1930

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

Do not use this space.

9878

1. PLACE OF DEATH

County Culachi  
Township Jaycox  
City Crocker (No. ....) St. .... Ward)

Registration District No. 716  
Primary Registration District No. 5905

File No. ....  
Registered No. 4

2. FULL NAME Lewis Hambleton Graves

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

Length of residence in city or town where death occurred 2 yrs. 9 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) Widower

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (or) WIFE of Russell Barr

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 11/11/1861

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 68 6 ✓

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work Contractor (Retired) (b) General nature of industry, business, or establishment in which employed (or employer) ✓ (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Wareau (STATE OR COUNTRY) Hickory Co., Missouri

10. NAME OF FATHER Emanuel Graves

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

12. MAIDEN NAME OF MOTHER Elizabeth Luthy

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

14. INFORMANT Mrs. Edna Kelly (Address) Crocker, Mo.

15. FILED 3/20/30 1930 REGISTRAR B. J. Bell

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar. 12 1930

17. I HEREBY CERTIFY That I attended deceased from Sept. 23, 1928 to Mar. 12, 1930 that I last saw him alive on Mar. 12, 1930, and that death occurred, on the date stated above, at 5:45 a.m.

18. CAUSE OF DEATH\* WAS AS FOLLOWS: Epilepsy of right face with metastasis involving right eye, prostate gland & bladder (duration) 3 yrs. 6 mos. ds.

CONTRIBUTORY (SECONDARY) 48 (duration) 52 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 48 515 588

19. DID AN OPERATION PRECEDE DEATH? no DATE OF Aug. 1928

20. WAS THERE AN AUTOPSY? no

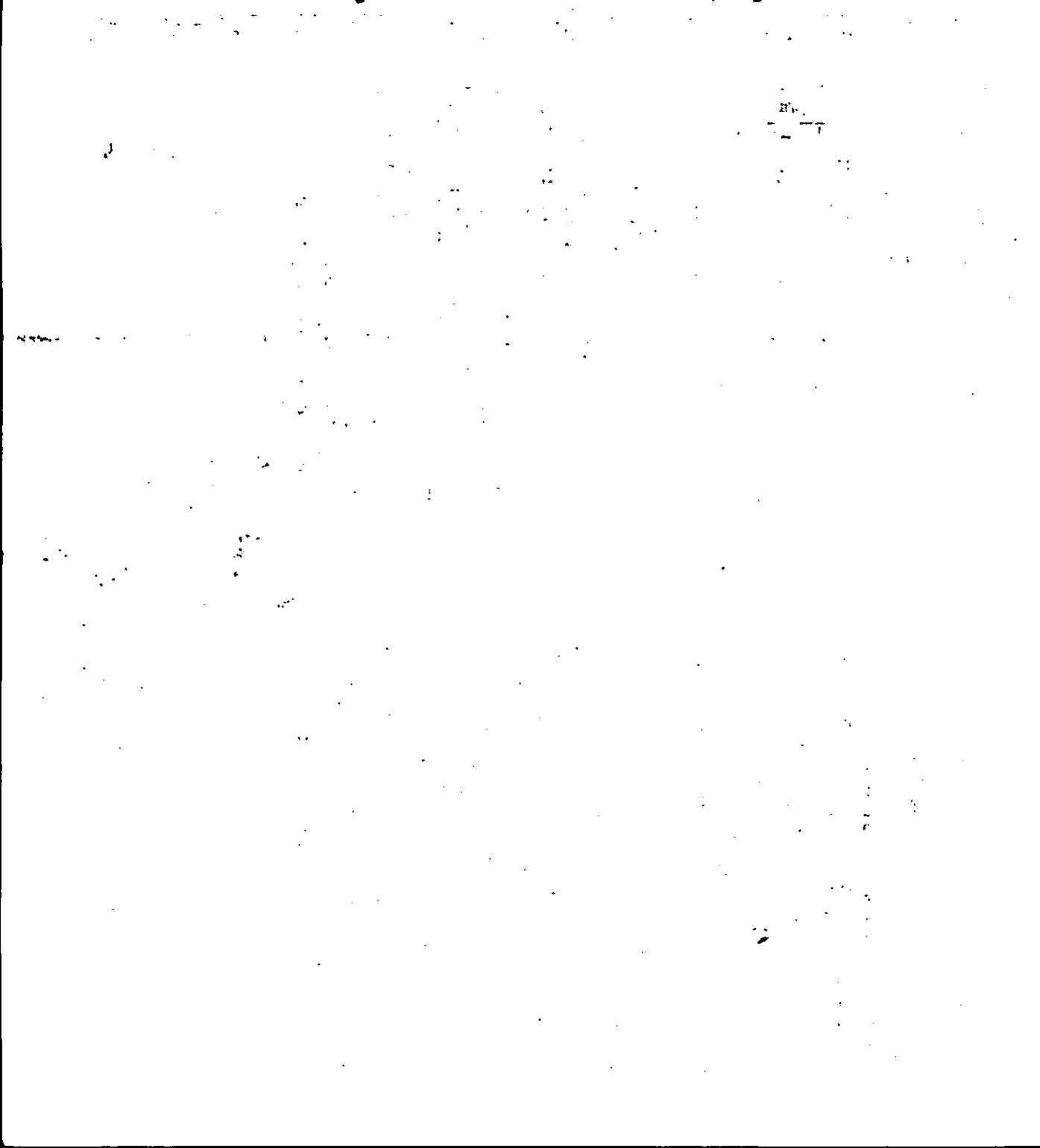
WHAT TEST CONFIRMED DIAGNOSIS? (Signed) C. Mallitt, M. D. Mar. 12 1930 (Address) Crocker, Mo.

\*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 New Hope Cemetery DATE OF BURIAL 3/13/30

20. URBERTAKER Hooper & Sons ADDRESS Crocker, 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.



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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Pulaski Registration District No. 716 File No. ....  
Township Haverhill Primary Registration District No. 5945 Registered No. 4  
City (No. ....) St. .... Ward)

**2. FULL NAME** Lewis Hamilton 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 | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

M | W | wid

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

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

Sept 17 1867

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, .... hrs. or .... min.

68 | 6 | 1 | 1

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)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.

INFORMANT (Address)

15.

FILED 3/13/30 N. J. Lee REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 12 1930

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....  
DID AN OPERATION PRECEDE DEATH..... DATE OF.....  
WAS THERE AN AUTOPSY.....  
WHAT TEST CONFIRMED DIAGNOSIS.....  
(Signed)....., M. D.  
, 19 (Address)

\*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

20. UNDERTAKER ADDRESS

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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