

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

Do not use this space.

12182

1. PLACE OF DEATH

County Douglas
Township ava
City ava (No. _____ St. _____ Ward)

Registration District No. 272
Primary Registration District No. 4165

File No. _____
Registered No. _____

2. FULL NAME

(a) Residence No. _____ St. _____ Ward. Thomas Jefferson Graves
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>		4. COLOR OR RACE <u>white</u>		5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____					
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>June 18 1861</u>					
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.	
<u>68</u>	<u>9</u>	<u>9</u>	<u>19</u>		
8. OCCUPATION OF DECEASED					
(a) Trade, profession, or particular kind of work <u>Retired Farmer</u>					
(b) General nature of industry, business, or establishment in which employed (or employer) _____					
(c) Name of employer _____					
9. BIRTHPLACE (CITY OR TOWN) <u>Winston</u> (STATE OR COUNTRY) <u>Kentucky</u>					
PARENTS	10. NAME OF FATHER <u>John P. Graves</u>				
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Kentucky</u> (STATE OR COUNTRY)				
	12. MAIDEN NAME OF MOTHER <u>Susan Butler</u>				
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Kentucky</u> (STATE OR COUNTRY)					
14. INFORMANT <u>M. H. Graves</u> (Address) <u>Marion Kentucky</u>					
15. FILED <u>4/29 1930</u> <u>B. Norman</u> REGISTRAR					

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 27 1930

17. I HEREBY CERTIFY, That I attended deceased from April 14 1930 to April 27 1930 that I last saw him alive on April 27 1930; and that death occurred, on the date stated above, at 9:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
chronic interstitial nephritis

131 (duration) / Heart yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 129 W (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED ava Mo

IF NOT AT PLACE OF DEATH. _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Smear, Biopsy
(Signed) Robt M Norman M. D.
, 19 ava Mo (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 <u>ava Mo.</u>	DATE OF BURIAL <u>4-29 1930</u>
20. UNDERTAKER <u>B. V. Christinghead</u>	ADDRESS <u>ava Mo</u>

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

