

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

39206

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

1. PLACE OF DEATH  
County Hickory Registration District No. 1052  
Township Wiley Primary Registration District No. 5570  
City Flemington (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Takitus Graves  
(a) Residence. No. Flemington St. mo. 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.

JAN 19 1930

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 24 1850

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	80	1	6	

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

9. BIRTHPLACE (CITY OR TOWN) Kentucky  
(STATE OR COUNTRY)

10. NAME OF FATHER Edward Graves

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

12. MAIDEN NAME OF MOTHER Mrs Garnett

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

14. INFORMANT Mrs. Tacius Graves  
(Address) Flemington Mo

15. FILED 1930 H. R. Marshall  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov - 29 - 1930

17. I HEREBY CERTIFY, That I attended deceased from Nov - 29 - 1930, to Nov - 30 - 1930 that I last saw him alive on Nov - 29 - 1930, 1930 and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
82.0 Neurophlegia  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 2 ds.

CONTRIBUTORY (SECONDARY) 75.0  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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

19. DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Physical Exam  
(Signed) D. S. Johnston M. D.  
Dec-1-1930 (Address) Wheatland 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 Roundtree Cemetery DATE OF BURIAL Dec. 3 1930

20. UNDERTAKER Wheatland ADDRESS Wheatland Mo

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.

