

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

Do not use this space.

10450

**1. PLACE OF DEATH**

County.....  
 Township.....  
 City.....

Registration District No. 791  
1005  
 Primary Registration District No. St. Louis Hospital

File No. ....  
 Registered No. 2499  
 St. .... Ward)

**2. FULL NAME**

Wm Graves  
 (a) Residence. No. 6668 Delmar St. 12 Ward. St. Louis Mo  
 (Usual place of abode) (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred 2 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 Divorced

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 2nd 1869

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

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work. Restaurant 246  
 (b) General nature of industry, business, or establishment in which employed (or employer). Owner  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Seneca  
 (STATE OR COUNTRY) N. Y.

10. NAME OF FATHER Eugene Graves

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

12. MAIDEN NAME OF MOTHER Margaret Waterlot

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

14. INFORMANT Curtis Graves  
 (Address) 235 S. Randolph

15. FILED 15 1932 Max E. Stork REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar. 14th 1932

17. I HEREBY CERTIFY, That I attended deceased from Feb 22, 1932, to March 14th, 1932 that I last saw him alive on March 14th, 1932, and that death occurred, on the date stated above, at 11:15 P. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Arterio Sclerosis, Hypertension

Chronic (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 1231 0

IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) John G. Kongeluan, M. D.

3/15/32 (Address) 6693 Delmar Blvd

\*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

Akron O. Mar 17 1932

20. UNDERTAKER ADDRESS 604

M. H. Marshall Union

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.

U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

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FEDERAL BUREAU OF INVESTIGATION

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

*Rec'd - 3-21-32*

**1. PLACE OF DEATH.**

County.....  
Township.....  
City..... (No. *Me. Bapt. Hspl.*)

Registration District No. *797*  
County Registration District No. *7*

File No.....  
Registered No. *2499*  
St. .... Ward)

**2. FULL NAME**

*William 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*) .....

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

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

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

**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 *Curta Graves*  
(Address) *2355 Randolph*

15. *MAR 28 1932* FILED *Mar 28 1932*

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *3-14-1932*

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) .....

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

*St Matthew Con* *Mar 28 1932*

20. UNDERTAKER *M H Marshall* ADDRESS *604 Madison*

SUPPLEMENTARY

N. B.—Every item information should be carefully supplied. A statement of OCCUPATION is very important. PHYSICIANS should state statement of OCCUPATION is very important. THEY ARE COMPLETE AS PRESCRIBED BY LAW. REGISTRATION SHALL NOT RECEIVE A FEE FOR CERTIFICATES.

S-10450