

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

Do not use this space.

18353

1. PLACE OF DEATH

County *Saline*
Township *Salt Fork*
City *97* (No. *97*)

Registration District No. *798*
Primary Registration District No. *6042*

File No.
Registered No.
St. Ward)

2. FULL NAME

William Shelton McGraw

(a) Residence, No. St. Ward.
(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.

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 *Beulah Clyde McGraw*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Nov. 29 1868*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<i>63</i>	<i>6</i>	<i>0</i>	

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 *✓*

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) *West Va.*

10. NAME OF FATHER *Champion McGraw*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Furley*
(STATE OR COUNTRY) *West Va.*

12. MAIDEN NAME OF MOTHER *Fannie Furrill*

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

14. INFORMANT *Clay McGraw*
(Address) *Napton Mo.*

15. FILED *4/3 19 32* *Mrs. Hall Williams*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *May 29 1932*

17. I HEREBY CERTIFY, That I attended deceased from *May 23* 19 *32* to *May 29* 19 *32* that I last saw him *alive on May 29 1932* and that death occurred, on the date stated above, *at 2:30 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchial pneumonia complicated with infection from recently expectorated teeth (duration) yrs. mos. ds. *9*

CONTRIBUTORY (SECONDARY) *12/1/31* (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED *①*
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) *R. W. Stouffer*, M. D.
, 19 (Address) *Napton Mo.*

*State the DISEASE CAUSING DEATH, 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 *Napton Cem.* DATE OF BURIAL *May 30 1932*

20. UNDERTAKER *W. M. Campbell* ADDRESS *Marshall*

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.

