DEC 2 1934

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

41746

1. PLACE OF DEATH
County [illegible] Registration District No. 879 File No.
Township Primary Registration District No. 6167 Registered No.
City Stotesbury 1770 (No. St. Ward)

2. FULL NAME Eldon P Graen
(a) Residence. No. St., Ward. (If nonresident give city or town and State)
(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 Anna L Graen
6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 18-1874
7. AGE Years 60 Months 4 Days 5 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) General Store
(c) Name of employer Self
9. BIRTHPLACE (CITY OR TOWN) Ft Scott
(STATE OR COUNTRY) Kansas

PARENTS
10. NAME OF FATHER Chas W Graen
11. BIRTHPLACE OF FATHER (CITY OR TOWN) None
(STATE OR COUNTRY) Germany
12. MAIDEN NAME OF MOTHER Ida Lowe
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Cincinnati
(STATE OR COUNTRY) Ohio

14. INFORMANT C Evans
(Address) 2219 & 26th St Kansas City Mo.

15. FILED Dec 6, 1934. Minnie B. Denton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 23 1934
17. I HEREBY CERTIFY, That I attended deceased from Nov. 22, 1934, to Nov 23, 1934 that I last saw h alive on , 19 , and that death occurred, on the date stated above, at 11 am m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
92a
A Cardiac Decompensation
B (duration) yrs. One mos. ds.
CONTRIBUTORY (SECONDARY) Mitral Stenosis (duration) 10 yrs. mos. ds.
18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
0 DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) H. S. Claypool Dr
, 19 (Address) Hume, 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Evergreen Cemetery Ft Scott Kan
DATE OF BURIAL Nov 25 1934
20. UNDERTAKER O A Cheney
ADDRESS Ft Scott Kans

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.

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....Ward)

2. FULL NAME .....

(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)

PARENTS

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....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

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:

.....
.....
.....
.....(duration).....yrs. .....mos.....ds.

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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
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.