LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

JUN 3 1935

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

Do not use this space.

6456-a

File No.
Registered No.

84

1. PLACE OF DEATH
County: Pol R
Township: W. Looney
City: Mountville (No. St. Ward)

Registration District No. 704
Primary Registration District No. 5933

2. FULL NAME: Joseph Marcus Degraffenreid

(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 75 yrs. 6 mos. 15 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): Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Widowed

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): August 5, 1859

7. AGE: Years 75 | Months 6 | Days 14 | If LESS than 1 day, hrs. or min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Blacksmith
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.:
10. Date deceased last worked at this occupation (month and year):
11. Total time (years) spent in this occupation:

1 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Dade Co.

FATHER
1 13. NAME: Joseph Marcus Degraffenreid
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Dade Co. Mo

MOTHER
2 15. MAIDEN NAME: Sarah Grider
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Kentucky

17. INFORMANT (ADDRESS): J. C. Degraffenreid

18. BURIAL, CREMATION, OR REMOVAL
PLACE: Oak Grove DATE: Feb. 19 1935

19. UNDERTAKER (ADDRESS): White Funeral Home Monroe City Mo

20. FILED: April 26, 1935 Grace Davis Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Feb. 18, 1935

22. I HEREBY CERTIFY, That I attended deceased from Feb. 17, 1935 to Feb. 18, 1935
I last saw him alive on Feb. 17, 1935. Death is said to have occurred on the date stated above, at 3:10 P.M.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Apoplexy	
920	

Other contributory causes of importance:

Name of operation: Date of
What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) W. J. Hanna, M. D.
(Address) Monroe City Mo.

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.

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CERTIFICATE OF DEATH

Do not use this space.

File No.....

Registered No.....

1. PLACE OF DEATH

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

Township..... Primary Registration District 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.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.....

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.....

10. Date deceased last worked at this occupation (month and year).....

11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN).....
(STATE OR COUNTRY)

FATHER

13. NAME

14. BIRTHPLACE (CITY OR TOWN).....
(STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN).....
(STATE OR COUNTRY)

17. INFORMANT.....
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE..... DATE.....19.....

19. UNDERTAKER.....
(ADDRESS)

20. FILED....., 19..... .....
Registrar.

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from .....19....., to.....19.....

I last saw h..... alive on.....19..... Death is said to have occurred on the date stated above, at.....m.

The principal cause of death and related causes of importance were as follows:

Date of onset

.....

.....

.....

.....

.....

Other contributory causes of importance:

.....

.....

.....

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury.....19.....

Where did injury occur?.....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

.....

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed)....., M. D.

(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.