~~LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT~~

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

1 JUN 26 1935

Do not use this space.

10085 — 6

File No. 181

Registered No. 181

1. PLACE OF DEATH

County Pemiscot

Township Braggadocia

City Braggadocia (No. ..... St. ..... Ward)

Registration District No. 653

Primary Registration District No. 5871

2. FULL NAME W. H. Graves

(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 M

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 7-25-1871

7. AGE YEARS 63 MONTHS 7 DAYS 25 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION

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

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) Baliver Tenn

FATHER

13. NAME John Graves

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

MOTHER

15. MAIDEN NAME D K

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

17. INFORMANT (ADDRESS) Ralph Graves Deering, Mo.

18. BURIAL, CREMATION, OR REMOVAL

PLACE Caruthersville DATE 3-31 1935

19. UNDERTAKER (ADDRESS) German Undt Co. Steele Mo.

20. FILED June 9 1935 J W Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-30 1935

22. I HEREBY CERTIFY, That I attended deceased from March 23, 1935, to March 30, 1935

I last saw him alive on March 29, 1935. Death is said to have occurred on the date stated above, at 8.30 P.m.

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

	Date of onset
Lobar Pneumonia	3/21/35

108

Other contributory causes of importance:

None

Name of operation ✓ Date of .....

What test confirmed diagnosis? ✓ 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?

If so, specify

(Signed) James P. Vickrey, M. D.

(Address) Steele, Mo.

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

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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.

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.