REC'D MAR 17 1938

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

Ag 6802
Do not use this space.

1. PLACE OF DEATH
(a) County Greene Registration District No. 318
(b) Township Primary Registration District No. 2001 Registered No. 163
(c) City Springfield Mo (d) Street No. 415 Delmar St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mrs Almina Grafton 613
(a) Residence, No. 415 Delmar St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
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 Joseph Grafton
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 19 1850
7. AGE ✓ YEARS 88 MONTHS 1 DAYS 2 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Home
9. Industry or business in which work was done, as 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) Craff Orchard Ky

FATHER
13. NAME Anderson Dyekan
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ky

MOTHER
15. MAIDEN NAME Jaan Davis
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ky

17. INFORMANT (ADDRESS) Mrs. Ted Whittenbur 415 Delmar
18. BURIAL, CREMATION, OR REMOVAL PLACE Willard Mo DATE Feb. 23 1938
19. FUNERAL DIRECTOR (ADDRESS) Alma Tohmey Springfield Mo
20. FILED Feb 21 1938 Chas A Georgette Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 21 1938
22. I HEREBY CERTIFY, That I attended deceased from Feb. 19, 1938, to Feb 21, 1938
I last saw her alive on Feb 20, 1938. Death is said to have occurred on the date stated above, at 7:10 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
~~Bron~~ Carcinoma of the face	1935
Other contributory causes of importance: Bronchial pneumonia 52	2-19-38

Name of operation none Date of
What test confirmed diagnosis? Biopsy 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) E. E. [signature], M. D.
(Address) Springfield, Mo

(Licensed Embalmer's Statement on Reverse Side)

WHITE 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.
I X12004

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STATEMENT BY LICENSED EMBALMER

I, Alma Lahmeyer, Licensed Embalmer No. 2790

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

.....L. E.....

No.....or by....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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1. PLACE OF DEATH
(a) County Greene — Registration District No. 318
(b) Township — Primary Registration District No. 2001 — Registered No. 163
(c) City Springfield — (d) Street No. ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Almina Grafton
(a) Residence, No. ..... St. ☐ .....
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): wid

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

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

7. AGE — YEARS: 88 — MONTHS: 1 — DAYS: 2 — If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as 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. FUNERAL DIRECTOR (ADDRESS)

20. FILED ..... 19 .....
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 21, 1938

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:

Carcinoma of the face — Date of onset
Primary Seat Skin of Nose
4-19-38

Other contributory causes of importance:
Bronchial Pneumonia
52-

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) E. E. Glenn, M. D.
(Address) Springfield Mo

SUPPLEMENTARY

S- 6802