

Registration District No. **247**

Primary Registration District No. **5342**

Registrar's No. **9**

FILED JUL 17 1940

1. PLACE OF DEATH:

(a) County Dallas
 (b) City or town Ekland-rural-Washington townsh
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: X
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution X
(Specify whether
 In this community life
years, months or days)

3. (a) PRINT FULL NAME John Franklin Graves

3. (b) If veteran, name war X 3. (c) Social Security No. X

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Etta Graves 6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased May 20, 1851
(Month) (Day) (Year)

8. AGE: Years 88 Months 11 Days 19 If less than one day X hr. X min.

9. Birthplace Webster Co., Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Farm

MOTHER FATHER { 12. Name Jackson Graves

13. Birthplace Tennessee
(City, town, or county) (State or foreign country)

14. Maiden name Melinda Martin

15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Lawrence Graves
 (b) Address Ekland, Missouri

17. (a) Burial (b) Date thereof May 11, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Martin cemetery

18. (a) Signature of funeral director W. J. Jolley
 (b) Address Marshfield, Missouri

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dallas
 (c) City or town rural - Ekland
(If outside city or town limits, write "RURAL")
 (d) Street No. Washington township
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? X years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 9
 year 1940 hour 9 minute P.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw h_____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
 Duration _____

Due to _____
 Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN _____
 Major findings: _____
 Of operations _____
 Of autopsy _____
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? 224

While at work? _____ (Specify type of place)
 (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

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.

20012

RECEIVED
District Health Officer No. 7,
District Health Number 6-40-872
Date Filed 6-18-40

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....X

.....X.....X.....X....., Registered Apprentice No. X
working under my personal supervision.

Signed [Signature]
Licensed Embalmer No. 312
P. O. Address Marshfield, Missouri

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.)

If this body is not embalmed, above space should be left blank.

This is the second
request for this
information. The
first sent on to the
undertaker at
Marshfield asking
for the information
never received any
reply. Have not
been able to get the
information but
am signing Certif-
icate as Local
Reg best I can
do L H Talbot
Paste on L R

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 21613

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 247

Primary Registration District No. 3342

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Dallas
(b) City Washington Twp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community _____ (Specify whether
years, month, days)

3. (a) PRINT FULL NAME John Franklin Graves

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 88 Months 11 Days 9 If less than one day _____ hr. _____ min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name _____
13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name _____
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

(Burial, cremation, or removal) (Place: burial or cremation)

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years

20. DATE OF DEATH Month May day 9 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) 2008

Major findings: Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? (City or town) (County) (State) _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

23. Signature L. J. Galbo L.P. (Specify type of place) While at work? _____ Means of injury _____
(M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD