No. 2
1-4-41
17-39
X28390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27838

FILED SEP 10 1941 85

Registration District No. .....

Primary Registration District No. 1001

Registrar's No. 829

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

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Crossing + R. R. Right-of-way (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether)

In this community Lifetime (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph (If outside city or town limits, write "RURAL")

(d) Street No. 2108 - S - 5th - St. (If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME Joseph-Last-Graves

3. (b) If veteran, name war ——

3. (c) Social Security No. 500-07-6348

4. Sex Male

5. Color or race Negro

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife .....

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased 2 (Month) - 14 (Day) - 1902 (Year)

8. AGE: Years 39 Months 6 Days 2 If less than one day ..... hr. ..... min.

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

10. Usual occupation Common-Laborer

11. Industry or business .....

FATHER
12. Name William-Graves
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Isabell-Williams
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Isabell-Graves

(b) Address 2108 S. 5th St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-18-41 (Month) (Day) (Year)

(c) Place: burial or cremation City-Cemetery

18. (a) Signature of funeral director Graves-Fun. Home

(b) Address 806 - S - 17th St.

19. (a) Aug. 18, 1941 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 16th year 1941 hour 12 minute 30 A. M.

21. I hereby certify that I ~~attended~~ viewed the deceased ~~from~~ on Aug 16 1941, to ....., 19....; that ~~I last saw it alive on~~ ....., 19....; and that death occurred on the date and hour stated above.

Immediate cause of death: Compressed Skull fracture of left parietal bone — Duration: 1 day

Due to: Left arm amputated at shoulder Both legs Crushed off.

Due to: Mans body found dead on the railroad tracks

Other conditions (Include pregnancy within 3 months of death): Mans body was mangled

Major findings: Of operation by the wheels of a rail road train

Of autopsy no

PHYSICIAN: 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) accident

(b) Date of occurrence Aug 16 - 1941

(c) Where did injury occur? St Joseph (City or town) Buch (County) Mo. (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Street Crossing and Rail Road right of way (Specify type of place)

While at work? no (e) Means of injury Train

23. Signature H. F. Mundy (M. D. or ~~other~~ Coroner)

Address 404 So 3d Date signed 8/18/41

(Licensed Embalmer's Statement on Reverse Side)

ST. JOSEPH

Not Embalmed

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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

If this body is not embalmed, fact should be so stated above.