

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No. 27

Registration District No. 461

Primary Registration District No. 3024

1. PLACE OF DEATH:

(a) County Salazette

(b) City or town Levinston N.J.A
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... (Specify whether
In this community About 45 yrs (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Salazette

(c) City or town Levinston 54
(If outside city or town limits, write "RURAL")

(d) Street No. South 9th 7 2
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)
If yes, name country..... 0

3. (a) PRINT FULL NAME ANDREW G. GRAVES

3. (b) If veteran, name war.....

3. (c) Social Security No. 994-01-2058

20. DATE OF DEATH: Month May day 5th
year 1942 hour 2 minute 00 A. M.

4. Sex Male 5. Color or race Negro

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

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

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

7. Birth date of deceased Not Known
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 2, 1942
to May 5, 1942
that I last saw him alive on May 4
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

About 70 hr. min.

Immediate cause of death Wound Duration

Due to High blood pressure

Due to nephritis (break down of kidneys)

Other conditions (include pregnancy within 3 months of death)

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

10. Usual occupation Coal miner

Major findings: Of operations.....

Of autopsy.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

11. Industry or business

12. Name Not Known

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

14. Maiden name Sadie Walker

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

16. (a) Informant John Armstrong

(b) Address Levinston Mo.

17. (a) Burial (b) Date thereof May 7/42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Levinston Mo

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?.....

While at work?..... (Specify type of place)

(e) Means of injury..... 3

18. (a) Signature of funeral director Winkler

(b) Address Levinston Mo

19. (a) 6/8/42 (b) Mrs. Fred Schurb
(Date received local registrar) (Registrar's signature)

23. Signature J. DeLoe (M. D. or other)
Address Levinston Mo Date signed June 5 1942

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

4
3

RECEIVED

District Health Officer No. 8,

Case File Number.....

Date Filed 6-18-42

157A-3141

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 Lio A. M. Keav

Licensed Embalmer No. 2983

P. O. Address Livington

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

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

Registration District No. 461

Primary Registration District No. 3024

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Lafayette

(b) City or town Livingston
(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 _____ (Specify whether _____)

In this community _____ years, months or days (Specify whether _____)

3. (a) PRINT FULL NAME Andrew S. Graves

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

4. Sex M 5. Color or race B 6. (a) Single, widowed, married, divorced W

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 70 Months _____ Days _____ If less than one day _____ 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)

(c) 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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day _____ year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____
that I last saw him/her 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)

Major findings:
Of operations _____

Of autopsy _____

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) _____

(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? _____

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

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

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

SUPPLEMENTAL

MOTHER FATHER

