DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 24 1942

Registration District No.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 30500

Primary Registration District No.

Registrar's No.

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

1. PLACE OF DEATH:

(a) County: Jackson

(b) City or town: Grain Valley (Sni-a-bar) (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Rural, 3Mi N*W (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days): 40 yrs

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson

(c) City or town: Grain Valley (Rural (If outside city or town limits, write "RURAL")

(d) Street No.: 3 Mi N*W (Sni a Bar TWP (If rural, give location)

(e) Citizen of foreign country? (Yes or No): 0

If yes, name country

3. (a) PRINT FULL NAME: James Arthur Graham

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

3. (c) Social Security No.: -

4. Sex: M 0

5. Color or race: W

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

6. (b) Name of husband or wife: Allie Lee

6. (c) Age of husband or wife if alive: 65 years

7. Birth date of deceased: June (Month) 12 (Day) 1878 (Year)

8. AGE: Years 69 | Months 2 | Days 29 | If less than one day: hr. min.

9. Birthplace: Jackson Co (City, town, or county) Mo (State or foreign country) 0

10. Usual occupation: Farmer

11. Industry or business:

FATHER
12. Name: Alfred Graham
13. Birthplace: Mo (City, town, or county) 0 (State or foreign country)

MOTHER
14. Maiden name: Bertha Holland
15. Birthplace: Mo (City, town, or county) 0 (State or foreign country)

16. (a) Informant: Edger Graham
(b) Address: Grain Valley Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9-12-42 (Month) (Day) (Year)
(c) Place: burial or cremation: Blue Springs Mo

18. (a) Signature of funeral director: Mrs G.B.Webb Son
(b) Address: Blue Springs Mo

19. (a) Sept 21/42 (Date received local registrar) (b) Mrs. John Lawson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 10 year 1942 hour 9 AM minute 30 A.M.

21. I hereby certify that I attended the deceased from May 12, 1942 to Sept 10, 1942 that I last saw him alive on Sept 10, 1942 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hypostatic pneumonia	3 Days
Due to: Myocardial degeneration	6 Mo
Due to: Hypertension	3 yrs
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature: L. N. Higgins (M.D. or other) M.D.
Address: Buckner Date signed: 9/11/42

1313 (Licensed Embalmer's Statement on Reverse Side)

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 R B White

Licensed Embalmer No. 2353

P. O. Address Blue Springs

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.

S. No. 2B
-8-21-41
J X29288

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1. PLACE OF DEATH:

(a) County: Jackson

(b) City or town: Rural
(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 years, months or days)
In this community .....

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 .....

3. (a) PRINT FULL NAME: James Arthur Graham

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: June (Month) 12 (Day) 1873 (Year)

8. AGE: Years 69 Months 2 Days ..... If less than one day: ..... hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

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

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

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

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....
(b) Address .....

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. Day 10 year 1942 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: Hypostatic Pneumonia (Lobar) — Interval: 3 days

Due to: myocardial degeneration — 6 mo.

Due to: Hypertension 3 yrs.

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

Major findings:
Of operations: 108
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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? .....
While at work? ..... (Specify type of place) (c) Means of injury .....

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

SUPPLEMENTARY