S. No. 2
M—5-47
5-17-39
X32873

FILED APR 8 1943

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

9085

State File No.

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1527

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: K.C. General Hospital No. 1 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 days (Specify whether In this community No record years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City (If outside city or town limits, write "RURAL") 5

(d) Street No. 309 Garfield (If rural, give location) 8

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

If yes, name country

3. (a) PRINT FULL NAME August Graser

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex M.

5. Color or race W.

6. (a) Single, widowed, married, divorced No record

6. (b) Name of husband or wife No record

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

7. Birth date of deceased June 24th 1867 (Month) (Day) (Year)

8. AGE: Years 75 Months 9 Days 2 If less than one day hr. min.

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

10. Usual occupation None listed

11. Industry or business

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

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

16. (a) Informant Record clerk
(b) Address K.C. General Hospital

17. (a) K.C. Dental College (Burial, cremation, or removal) (b) Date thereof 3-31-43 (Month) (Day) (Year)
(c) Place: burial or cremation Kansas City Mo.

18. (a) Signature of funeral director Snow - Mulgrew
(b) Address 2315 Linwood

19. (a) 3/30/43 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 26th year 1943 hour 5 minute 20 A.M.

21. I hereby certify that I attended the deceased from 3-18-43, 19 to 3-26-43, 19; that I last saw him alive on 3-26-43, 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic cystitis due to probable malignancy, site undetermined	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy None

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 Drury R. Thom (M. D. or other)
Address Med. Dir. K.C. General Hospital Date signed

(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.....

Licensed Embalmer No.....

P. O. Address.....

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, fact should be so stated above.

S. No. 2B
M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 9585

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1527

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(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)

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 August Graser

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 Unk.

6. (b) Name of husband or wife

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

7. Birth date of deceased June (Month) 24 (Day) 1867 (Year)

8. AGE: Years 75 Months 9 Days 2 If less than one day hr. min.

9. Birthplace (City, town, or county) Wisc (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) 2/30 (Date received local registrar) 43 (b) M. M. Crow (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 26 year 1943 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 Chronic Cystitis due to probably malignancy site undetermined

Due to

Due to

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

Major findings:
Of operations 55e

Of autopsy

Duration

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 Drury R. Thorn (M.D. or other)

Address General Hosp. Date signed

SUPPLEMENTARY