

ED JUL 9 1943
Registration District No. 164

Primary Registration District No. 3073

State File No. _____
Registrar's No. 62

1. PLACE OF DEATH:
(a) County Johnson
(b) City or town Warrensburg.
(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 30 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Johnson
(c) City or town Warrensburg. (If rural, give location)
(d) Street No. 111 Grover
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME John Samuel Graham

MEDICAL CERTIFICATION

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

20. DATE OF DEATH, Month June, day 13, year 1943, hour 3 minute 20 P M.

4. Sex Male 5. Color W 6. (a) Single, widowed, married, divorced 1

21. I hereby certify that I attended the deceased from May 15 1943 to June 13 1943 that I last saw him alive on 6-13 1943 and that death occurred on the date and hour stated above.

6. (b) Name of husband or wife Cora Graham 6. (c) Age of husband or wife if alive 75 years

Immediate cause of death Cerebral Arteriosclerosis

7. Birth date of deceased June 6 1864
(Month) (Day) (Year)

Due to _____
Due to _____

8. AGE: Years 79 Months 0 Days 7 If less than one day hr. _____ min.

Other conditions Capsiculae 1 month ago
(Include pregnancy within _____ months of death)

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

Major findings: Of operations _____

10. Usual occupation Farmer.

Of autopsy _____

11. Industry or business _____

12. Name John Guy Graham

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

14. Maiden name Nancy Hobson

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

16. (a) Informant Cora Graham

(b) Address Warrensburg, Mo

17. (a) Burial (b) Date thereof June 15, 43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Centerview Mo

18. (a) Signature of funeral director Sweeney-Phillips

(b) Address Warrensburg, Mo

19. (a) June 14 1943 (b) Teala M. Williams
(Date received local registrar) (Registrar's signature)

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 P. Lee Cooper (M. D. or other) MD
Address Warrensburg, Mo Date signed 6-14-43

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

RECEIVED

District Health Officer No. 8.

District File Number

Date Filed

2-8-43

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

S. Ray Sweeney

Licensed Embalmer No.

1121

P. O. Address

Warrenton

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

JUL 12 1942

Registration District No. 104Primary Registration District No. 3023Registrar's No. 62

1. PLACE OF DEATH:

- (a) County Johnson
 (b) City or town Warrensburg
 (If outside city or town limits, write "RURAL" and location 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) 30 yrs3. (a) PRINT FULL NAME John S. Graham

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

3. (c) Social Security No. _____

4. Sex
- ma
5. Color or race
- wo

6. (a) Single, widowed, married, divorced
- married
-
6. (c) Age of husband or wife if alive
- 75
- years

6. (b) Name of husband or wife _____

7. Birth date of deceased
- June 6 - 1866

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

79

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 _____

(Burial, cremation, or removal)

(Month) (Day) (Year)

(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 _____ day _____
-
- year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;
-
- that I last saw him _____ at _____ 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)

Major findings:

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline
the cause to
which death
should be
charged sta-
tistically.

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

5-21718