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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 25649

FILED AUG 12 1943

Registration District No. 25-1

Primary Registration District No. 3048

Registrar's No. 123

1. PLACE OF DEATH:

(a) County Madison

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

(c) Name of hospital or institution: St. Francis Hospital  
(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

3. (a) PRINT FULL NAME Martha Colan Graves

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

3. (c) Social Security No. \_\_\_\_\_

4. Sex female 5. Color or race W

6. (a) Single, widowed, married, divorced 0

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

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

7. Birth date of deceased July 31 1943  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day 6 hr. 30 min.

9. Birthplace Marysville Mo. 0  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Winfred Walter Graves

13. Birthplace Fairfax Mo. 0  
(City, town, or county) (State or foreign country)

14. Maiden name Egde Lenora Brewer

15. Birthplace Fairfax Mo. 0  
(City, town, or county) (State or foreign country)

16. (a) Informant Winfred Graves

(b) Address Fairfax Mo

17. (a) Rural (b) Date thereof 8-1-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pleasant Ridge Co

18. (a) Signature of funeral director P. W. funeral home

(b) Address Marysville Mo

19. (a) Aug. - 4 - 1943 (b) Amy Barber  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Atchison <sup>3</sup>

(c) City or town Fairfax <sup>0</sup>  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) If foreign born, how long in U. S. A? 1 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 1 year 1943 hour 30 minute 20 a.m.

21. I hereby certify that I attended the deceased from July 31, 1943 to Aug 1, 1943  
that I last saw her alive on July 31, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death patent foramen ovale <sup>6'sho.</sup>

Due to prematurity

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 157e

Major findings: Of operations \_\_\_\_\_

Of autopsy patent foramen ovale

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 10

23. Signature H. C. Bauman (M. D. or other) MD

Address Fairfax Date signed 8-3-43

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

MOTHER FATHER

**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. *not embalmed*

Signed: *Clem M. Price*

Licensed Embalmer No. *1822*

P. O. Address *Maryville, N*

**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.**