

No. 9-4-41
17-39
X29281

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

35542

State File No. _____

FILED NOV 15 1943
Registration District No. 90

Primary Registration District No. 5985

Registrar's No. 1183

1. PLACE OF DEATH:
(a) County Pulaski
(b) City or town Big Piney, Mo. (Rural)
(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 1 Yr. years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Pulaski
(c) City or town Big Piney (Rural)
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Ruby Irene Graves
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept day 19
year 1943 hour 11:50 P.M. M.
21. I hereby certify that I attended the deceased from 9-19- 1943 to 9-19- 1943
that I last saw her alive on 9-19-43 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Wm. Roy Graves 6. (c) Age of husband or wife if alive 45 years
7. Birth date of deceased October 17 1913
(Month) (Day) (Year)

Immediate cause of death _____
uterine hemorrhage
Due to _____
Child birth
Other conditions (Include pregnancy within 3 months of death) _____

8. AGE:	Years	Months	Days	If less than one day
<u>29</u>	<u>29</u>	<u>11</u>	<u>2</u>	_____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Benjamin Buchatzer
13. Birthplace Not known
(City, town, or county) (State or foreign country)
14. Maiden name Pearl Sheron
15. Birthplace Kansas City, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Wm. R. Graves
(b) Address Big Piney, Mo.

17. (a) Removal (b) Date thereof 9-21-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kansas City, Mo.

18. (a) Signature of funeral director J. L. Hoops & Sons
(b) Address Crocker, Mo.

19. (a) 11-8-1943 (b) Chas M. D...
(Date received local registrar) (Registrar's signature)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
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 C. Miller M.D. (M. D. or other) _____
Address Waynesville Date signed 9-20-13

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

1170

(Licensed Embalmer's Statement on Reverse Side)

JUN 18 1956

Oct. 7 - 1943
11
77
1866
77-
77-
25
19

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 Paul B. Hoops
Licensed Embalmer No. 3261
P. O. Address Grocher, Mo.

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.

Registration District No. 290 Primary Registration District No. 5985

1. PLACE OF DEATH
(a) County Pulaski
(b) City or town Big Piney 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)
In this community years, months or days

3. (a) PRINT FULL NAME Ruby Irene Graver
3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced mc
6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive yes

7. Birth date of deceased Oct 17 (Month) (Day) (Year)
8. AGE: Years 29 Months 11 Days 14 (If less than one day, min.)

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

10. Usual occupation

11. Industry or business

MOTHER FATHER
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) (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)

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 that I last saw him alive on and that death occurred on the date and hour stated above.
Immediate cause of death

uterine hemorrhage
Due to 146c
Due to child birth - Delivery - hemorrhage 3 1/2 hrs after delivery -
Other conditions Doctor was 20 miles away and death occurred before his arrival
(Include pregnancy within 3 months of death)

Major findings:
Of operations arrival There was no laceration and patient had both
Of autopsy organs and p. uterine following delivery

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 (M, D. or other)
Address Date signed

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

35542