

FILED JAN 14 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42751**

Registration District No. **170**

Primary Registration District No. **5634**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Laclede**
(b) City or town **Lebanon (Rural) Springhollow**
(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 **WM. RUSSELL GRAVES**

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

4. Sex **M** 5. Color or race **W** 6. (e) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Mary Jane Graves** 6. (c) Age of husband or wife if alive **63** years
7. Birth date of deceased **May 30 1870**
(Month) (Day) (Year)

8. AGE: Years **73** Months **6** Days **5** If less than one day _____ hr. _____ min.

9. Birthplace **Webster Co** **mo** **0**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business

MOTHER FATHER { 12. Name **L. W. Graves**
13. Birthplace **Kavanaugh Ill** **1**
(City, town, or county) (State or foreign country)
14. Maiden name **Anna Pattie**
15. Birthplace **Dallas Co** **mo** **0**
(City, town, or county) (State or foreign country)

16. (a) Informant **Harner Graves**
(b) Address **Conway mo R# 1**
17. (a) **Burial** (b) Date thereof **Dec 8 1943**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Old Lutheran Cemetery**
18. (a) Signature of funeral director **W. E. Holman**
(b) Address **Lebanon mo**
19. (a) **Dec 31-43** (b) **Grace Roper**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Laclede** **53**
(c) City or town **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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **5**
year **1943** hour **12** minute **15** AM.

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 **Heart attack** **Duration** _____

Due to **Old age & arteriosclerosis**

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 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 **Carriage**

23. Signature **J. D. Stuckert** **3** (M.D. or other) **Coroner**
Address **Lebanon mo** Date signed **12-13**

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

Received

Laclede County Health Unit

File No. 12-43-182

Date Filed 1-12-44

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 Dorsey M. Howe

Licensed Embalmer No. 4222

P. O. Address Lebanon 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan
Registrar's No. _____

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
 (a) County Laclede
 (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
 In this community _____ years, months or days)

3. (a) PRINT FULL NAME Wm. P. Graves
 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 on
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive 63 year
 7. Birth date of deceased May 30 (Month) (Day) (Year)

8. AGE: Years 73 Months 6 Days 18 If less than one day _____ min.

9. Birthplace Mo. (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 _____ (Month) (Day) (Year)
 (Burial, cremation, or removal)

(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 _____ year 1943 minute _____ M.
 21. I hereby certify that I attended the deceased from _____ 19____; _____ 19____;
 that I last saw him _____ alive on _____ 19____;
 and that death occurred on the date and hour stated above
 immediate cause of death heart attack

Due to _____
 Due to _____

Other conditions (include pregnancy within 3 months of death) _____
 Major findings: _____
 Of operations _____
 Of autopsy _____

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 Coroner
 23. Signature James D. Stauter (M.D. or other) _____
 Address _____ Date signed _____

SUPPLEMENTARY

Chronic Myocarditis

936

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

MOTHER FATHER

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

S-42751