

FILED FEB 10 1944

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 4660

Registration District No. 238

Primary Registration District No. 6148

Registrar's No.

1. PLACE OF DEATH: Stoddard

(a) County Stoddard

(b) City or town Bloomfield Rural Castor

(c) Name of hospital or institution: *Surf*

(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 Mo. (b) County Stoddard

(c) City or town Bloomfield Mo. (If outside city or town limits, write "RURAL")

(d) Street No. --- (If rural, give location)

(e) Citizen of foreign country? U.S.A. (Yes or No)

If yes, name country: ---

3. (a) PRINT FULL NAME Ralph Leon Graves

3. (b) If veteran, name war: --- (c) Social Security No. ---

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced: --- U

6. (b) Name of husband or wife: --- 6. (c) Age of husband or wife if alive: --- years

7. Birth date of deceased: Dec. 12 1943 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

--- --- --- 1 hr. --- min.

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

10. Usual occupation: ---

11. Industry or business: ---

12. Name Ralph A. Graves

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

14. Maiden name: Nurcine Lewis

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

16. (a) Informant: Ralph A. Graves

(b) Address: Bloomfield, Mo. R. #3

17. (a) Burial (b) Date thereof: 12-13-43 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Zion Cemetery

18. (a) Signature of funeral director: Chiles Und. Co.

(b) Address: Bloomfield, Mo.

19. (a) Jan 6 1944 (b) Pearl Chure (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 12 year 1943 hour 9 minute 55

21. I hereby certify that I attended the deceased from: 12-12-43 to 12-12-43 that I last saw him alive on Dec. 12-1943 and that death occurred on the date and hour stated above.

Immediate cause of death: *Chromosome Birth* Duration  
*Cause unknown*

Due to: ---

Due to: ---

Other conditions: --- (include pregnancy within 3 months of death)

Major findings: --- Of operations: ---

Of autopsy: *no*

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): *no*

(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: *S.S. Lewis* (M. D. or other)

Address: *Wester Mo* Date signed: 12/13/43

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

1130

RECEIVED

District Health Office No.

District File Number 244-25

Date Filed 2-7-44

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**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.....

Child was not embalmed

....., 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.**