DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 30 1944

Registration District No. 42

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21089

Primary Registration District No. 1020

Registrar's No. 642

1. PLACE OF DEATH:

(a) County Buchanan

(b) City ~~or town~~ St. Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hospital No. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 days (Specify whether
In this community 6 days - years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper

(c) City ~~or town~~ Carthage
(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 AMOS GRAHAM.

3. (b) If veteran, name war unknown

3. (c) Social Security No. unknown

4. Sex Male

5. Color or race Negro

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

6. (b) Name of ~~husband or~~ wife Lillian P. Graham

6. (c) Age of ~~husband or~~ wife if alive unknown years

7. Birth date of deceased 12 - 6 - 1906.
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	37	5	6	hr. min.

9. Birthplace Portland (City, town, or county) Arkansas (State or ~~foreign country~~)

10. Usual occupation unknown

11. Industry or business unknown

FATHER
12. Name unknown
13. Birthplace unknown (City, town, or county) unknown (State or foreign country)

MOTHER
14. Maiden name unknown
15. Birthplace unknown (City, town, or county) unknown (State or foreign country)

16. (a) Informant Deputy Sheriff Harold Jones.

(b) Address Carthage Missouri.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 - 16 - 1944 (Month) (Day) (Year)

(c) Place: burial or cremation Asylum Cemetery

18. (a) Signature of funeral director Ramsey Son

(b) Address 1602 Missouri

19. (a) 5/16/44 (Date received local registrar) (b) Helen I. Pickle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 12
year 1944 hour 5 minute 30 P. M.

21. I hereby certify that I attended the deceased from 5-7-, 1944 to 5-12-, 1944
that I last saw him alive on 5-12-, 1944
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bronchopneumonia	4 days
Due to gangrenous pectoritis	
Due to Punctured wound of anterior abdomen	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations Had an exploratory operation -	
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? Carthage (~~City or~~ town) Jasper (County) Missouri (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 J. H. Morrowey (M. D. ~~or other~~)

Address State Hospital No. 2 Date signed 5-12-44

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(Licensed Embalmer's Statement on Reverse Side)

not embalmed.

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

J. F. Ramsey not embalmed, Registered Apprentice No.

working under my personal supervision.

Signed J. F. Ramsey

Licensed Embalmer No. 4081

P. O. Address 1602 Mesa

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com 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 CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. July 642

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 642

1. PLACE OF DEATH:

(a) County: Buchanan

(b) City or town: St Joseph
(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 years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

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

(d) Street No.

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Amos. Graham

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race B

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Dec 14 1908 (Month) (Day) (Year)

8. AGE: Years 37 Months 5 Days If less than one day hr. min.

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

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)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month July 1944 year hour M.

21. I hereby certify that I attended the deceased during the period from , 19 ; that I last saw him alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death

Due to

Due to

Duration

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 5/0/1944

(c) Where did injury occur? No information (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Jasper County Jail (Specify type of place)

While at work? No. (e) Means of injury

23. Signature Jas. H. Warren (M.D. or other)

Address State Hospital No. 2 Date signed

SUPPLEMENTAL

This man entered the hospital moribund. Autopsy showed perforated appendicitis, peritonitis, shallow ulcer of duodenum, shallow ulcer of jejunum, chronic pancreatitis, chronic colitis, etc. Cause of death was pneumonia, lobar, perforation of appendicitis, but primary cause could not be determined.

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