

FILED JUL 20 1944
Registration District No. **175**

Primary Registration District No. **3008**

Registrar's No. **212**

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

14
2-1

1. PLACE OF DEATH:

(a) County Callaway

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

(c) Name of hospital or institution:
State Hosp. #1 **2**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution from June 30-36
(Specify whether)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Andrew **14**

(c) City or town Amazona **1**
(If outside city or town limits, write "RURAL") **2**

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

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____ **0**

3. (a) PRINT FULL NAME Peter M. Graves

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

4. Sex male 5. Color or race white

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

6. (b) Name of husband or wife Anna Graves 6. (c) Age of husband or wife if alive? _____ years

7. Birth date of deceased Don't know
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 17
year 1944 hour 8 minute 15 P. M.

21. I hereby certify that I attended the deceased from June 30, 1936, to June 17, 1944
that I last saw him alive on June 17, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis

Duration _____

8. AGE:

Years	Months	Days	If less than one day
<u>71</u>	<u>?</u>	<u>?</u>	hr. _____ min. _____

Due to _____

Due to _____

9. Birthplace Don't know **9**
(City, town, or county) (State or foreign country)

10. Usual occupation Don't know

Other conditions Major Depressive Psychosis
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations 9.3d

Of autopsy _____

11. Industry or business _____

MOTHER { 12. Name Don't know

13. Birthplace Don't know **9**
(City, town, or county) (State or foreign country)

14. Maiden name Don't know

15. Birthplace Don't know **9**
(City, town, or county) (State or foreign country)

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? _____

(Specify type of place)

While at work? _____ (e) Means of injury _____

16. (a) Informant Per Corp. records

(b) Address _____

17. (a) Removal (b) Date thereof 6/18/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Savannah, Mo.

18. (a) Signature of funeral director Waller Funeral Home

(b) Address Fulton, Mo. B. B. Browning, Mgr.

19. (a) 6-18-1944 (b) Joie M. ...
(Date received local registrar) (Registrar's signature)

23. Signature P. S. Tate (M. D. or other) _____

Address State Hosp. #1 - Fulton Mo. Date signed 6-17-44

PHYSICIAN

Underline the cause to which death should be charged statistically.

1M 7

RECEIVED

District Health Officer No. 9,

District File Number

Date Filed 7-19-44

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 *Denzil C. Browning*

Licensed Embalmer No. *2724*

P. O. Address. *Haltom 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.