

S. No. 2  
OM-2-43  
v. 5-17-39  
X35697

34925

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILLED NOV 13 1944  
STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. \_\_\_\_\_

Registration District No. 293 Primary Registration District No. 4393

7400  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:  
(a) County Madaway  
(b) City or town Graham  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: None  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution None  
In this community 40 yrs  
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Madaway  
(c) City or town Graham  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME Finley Kaufman  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Oct day 12 11th  
year 44 hour 9 minute 30 M.  
21. I hereby certify that I attended the deceased from Jan  
1, 1943, to Oct 12 11th, 1944  
that I last saw him alive on Oct 12 11th, 1944  
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced MO  
6. (b) Name of husband or wife Anna 6. (c) Age of husband or wife if alive 79 years  
7. Birth date of deceased Mar 16 1863  
(Month) (Day) (Year)

Immediate cause of death Mitral Insufficiency Duration 1 yr  
Due to Old age

8. AGE: Years Months Days If less than one day  
81 6 25 hr. min.

Due to \_\_\_\_\_  
Other conditions chronic Prostatitis many years  
(Include pregnancy within 3 months of death)

9. Birthplace Unknown Ohio  
(City, town, or county) (State or foreign country)  
10. Usual occupation Retired

Major findings: Of operations ✓ A28  
Of autopsy ✓  
Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business \_\_\_\_\_  
12. Name Joseph Kaufman  
13. Birthplace Unknown Ohio  
(City, town, or county) (State or foreign country)  
14. Maiden name Hannah Bager  
15. Birthplace Unknown Ohio  
(City, town, or county) (State or foreign country)

16. (a) Informant Gene Kaufman  
(b) Address Graham Mo  
17. (a) Burial (b) Date thereof 10-14-44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation 2007 Graham

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 \_\_\_\_\_

18. (a) Signature of funeral director Campbell Funeral Home  
(b) Address 4M Annville Missouri  
19. (a) 10-14-44 (b) Mrs John Hockenbuhl  
(Date received local registrar) (Registrar's signature)

23. Signature E. L. Morgan (M. D. or other) U  
Address Graham Date signed 10/14/44

**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.....

*Marjorie Luke Campbell*, Registered Apprentice No. *360*  
working under my personal supervision.

Signed *William Campbell*

Licensed Embalmer No. *2690*

P. O. Address *Marquette 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.**