

S. No. 2
M-8-43
5-17-39
X37823

37805

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED DEC 12 1944

Registration District No. _____

Primary Registration District No. 5013

Registrar's No. 99

1. PLACE OF DEATH:
(a) County: ANDREW
(b) City or town: RIEFLD. # 2 SAVANNAH
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
ROUTE # 2, SAVANNAH
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 4 months
(Specify whether
In this community: Lifetime
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: MISSOURI (b) County: BUCHANAN
(c) City or town: 1319 NO. 3RD ST.
(If outside city or town limits, write "RURAL")
(d) Street No.: ST. JOSEPH, MISSOURI
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country: _____

3. (a) PRINT FULL NAME: Rosa E. Graham
3. (b) If veteran, name war: None
3. (c) Social Security No.: None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 11 day 20
year 1944 hour 9 minute 20 P.M.

4. Sex: Female 5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: John W.
6. (c) Age of husband or wife if alive: 72 years
7. Birth date of deceased: September 6, 1871
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 9
14 1944 to 11-20 1944
that I last saw her alive on Nov. 18 1944
and that death occurred on the date and hour stated above.
Immediate cause of death: Mitral insufficiency Duration 1 yr

8. AGE: Years 73 Months 1 Days 14
If less than one day hr. _____ min. _____

Due to: _____
Due to: _____

9. Birthplace: Buchanan Co., Missouri
(City, town, or county) (State or foreign country)

Other conditions: _____
(Include pregnancy within 3 months of death)

10. Usual occupation: Housewife

Major findings: _____
Of operations: _____

11. Industry or business: Home

Of autopsy: _____
PHYSICIAN
Underline the cause to which death should be charged statistically.

12. Name: John Thomas Chilcoat

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

14. Maiden name: Huldy Chilcoat

15. Birthplace: Morgan Co., Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant: John W. Graham (Husband)

(b) Address: 1319 No. 3rd St., City

17. (a) Burial (b) Date thereof: 11/22/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Hewitt Cem, Savannah

18. (a) Signature of funeral director: J. H. C. Crupp

(b) Address: 6054 Pryor Ave., City

19. (a) 11-22-44 (b) J. H. C. Crupp
(Date received local registrar) (Registrar's signature)

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? Mo.

While at work? _____ (Specify type of place)
(e) Means of injury: ?

23. Signature: Ralph H. Poffly (M. D. or other) _____

Address: Savannah, Ga. Date signed: 11/20/44

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

2000

1072 (Licensed Embalmer's Statement on Reverse Side)

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 John E. Rupp
Licensed Embalmer No. 9986
P.O. Address A. Joseph, 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.