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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 40126

FILED DEC 22 1944

Registration District No. _____ Primary Registration District No. 1002 Registrar's No. 4961

4

1. PLACE OF DEATH:

(a) County: JACKSON

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

(c) Name of hospital or ~~institution~~: ST. JOSEPH HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or ~~institution~~ 1-DAY (Specify whether years, months or days)

In this community 1 YEAR

2. USUAL RESIDENCE OF DECEASED:

(a) State: MISSOURI (b) County: JACKSON

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

(d) Street No. 4017 EAST 69TH STREET TERR.
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME: WILLIAM WOODARD GRAHAM, JR.

3. (b) If veteran, name war: NO

3. (c) Social Security No. NONE

4. Sex: MALE

5. Color or race: WHITE

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

6. (b) Name of husband or wife: ----

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

7. Birth date of deceased: JUNE (Month) 8 (Day) 1943 (Year)

8. AGE: Years 1 | Months 15 | Days 29 | If less than one day ____ hr. ____ min.

9. Birthplace: KANSAS CITY (City, town, or county) MISSOURI (State or foreign country)

10. Usual occupation: INFANT

11. Industry or business: ----

MOTHER FATHER

12. Name: WILLIAM WOODARD GRAHAM SR

13. Birthplace: KANSAS CITY (City, town, or county) MISSOURI (State or foreign country)

14. Maiden name: GENEVA TROUTMAN

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

16. (a) Informant: MR. WILLIAM WOODARD GRAHAM, SR

(b) Address: 4017 EAST 69TH STREET TERR

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: DEC-9-1944 (Month) (Day) (Year)

(c) Place: burial or cremation: MEMORIAL PARK CEM.

18. (a) Signature of funeral director: D. H. Newcomer's Sons

(b) Address: 1401 BRUSH CREEK BLVD.

19. (a) DEC 8, 1944 (Date received local registrar) (b) J E Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC. day 7TH year 1944 hour 1 minute 45 A.M.

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

	Duration
Immediate cause of death: Acute myocarditis and acute fibrinous pericarditis	
Due to: Acute cellulitis and periostitis of the right leg	
Due to:	
Other conditions (Include pregnancy within 3 months of death): 930	

Major findings:
Of operations: as above (periostitis) (cellulitis)
Of autopsy: As above

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? (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

23. Signature: Laine Sherwood (M. D. or other)

Address: Pathologist Date signed

(Licensed Embalmer's Statement on Reverse Side) St. Joseph Hospital, K.C., Mo.

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 Elsear Hartley

Licensed Embalmer No. 1767

P. O. Address Kansas City

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.