S. No. 2
M—5-42
5-17-39
P I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 19 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 2094

Registration District No. 99 Primary Registration District No. 4169 Registrar's No. 251

1. PLACE OF DEATH:

(a) County Dekalb

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

(c) Name of hospital or institution: home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ✓ (Specify whether

In this community ✓
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dekalb ?

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

(d) Street No. none
(If rural, give location)

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

If yes, name country /

3. (a) PRINT FULL NAME Jacob Graeff

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex male 0

5. Color or race white

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

6. (b) Name of husband or wife Minnie Graeff

6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased January (Month) 28 (Day) (Year)

8. AGE: Years 84 Months 10 Days 22 If less than one day ___ hr. ___ min.

9. Birthplace Milesville, New York (City, town, or county) (State or foreign country)

10. Usual occupation farming

11. Industry or business

FATHER
12. Name John Graeff
13. Birthplace ? (City, town, or county) Germany (State or foreign country)

MOTHER
14. Maiden name Christina Johanna Schwendall
15. Birthplace Bavaria, Germany (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Minnie Graeff
(b) Address Osborn Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 20 1944 (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director F G Lyon
(b) Address Stewartsville Mo.

19. (a) Dec 21 1944 (Date received local registrar) (b) John Clarke (Registrar's signature)

1579

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 20
year 19xx hour 4 minute 20 M.

21. I hereby certify that I attended the deceased from Nov 12, 19xx, to Dec- 20, 19xx, that I last saw him alive on Dec- 20, 19xx and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death apoplexy	
Due to	
Due to	
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

(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 0

23. Signature M. S. Gale M.D. ~~(M. D. or other)~~

Address Osborn Mo Date signed 12/21/xx

(Licensed Embalmer's Statement on Reverse Side)

JAN 21 1946

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.....F G Lyon.....

Licensed Embalmer No.....952 -.....

P. O. Address.....Stevensville.....

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.