

FILED MAR 3 1945
Registration District No. 280

Primary Registration District No. 0965

State File No. _____

Registrar's No. 2

1. PLACE OF DEATH:

(a) County Platte
(b) City or town Rural Preston
(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 no (Specify whether)
In this community Entire life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Platte
(c) City or town Rural Preston township
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME James Logan Graves

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

4. Sex male 5. Color or race white
6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife, XX
6. (c) Age of husband or wife if alive XX years

7. Birth date of deceased November 28 1862
(Month) (Day) (Year)

8. AGE: 83 Years 2 Months 15 Days
If less than one day
hr. _____ min. _____

9. Birthplace Weston Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Ira Ellis Graves

13. Birthplace XX Tenn.
(City, town, or county) (State or foreign country)

14. Maiden name Cynthia Lovelady

15. Birthplace Weston Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Tom Graves

(b) Address Smithville, Missouri

17. (a) Burial (b) Date thereof Feb. 14, 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Bethel Cemetery

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

(b) Address Weston Missouri

19. (a) 2-12-45 (b) Mrs. Clay Riffe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 12
year 1945 hour 11 minute 10 A.M.

21. I hereby certify that I attended the deceased from Jan 2 1945 to Feb 12 1945
that I last saw him alive on Feb 12 1945
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Cardiac & Respiratory failure

Due to arteriosclerosis

Other conditions vascular disease
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy 12481

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 _____

23. Signature Dr. R. E. Scott (M.D. or other) _____

Address Smithville Mo (City, town, or county) _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

1209

(Licensed Embalmer's Statement on Reverse Side)

2/12/45

RECEIVED

District Health Officer No. *Platte Co Health Office*
District File Number *3-45-26*
Date Filed *3-1-45*

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 *W. R. Vaughn*

Licensed Embalmer No. *4023*

P. O. Address *Weston, 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: