

FILED APR 19 1945

Registration District No. _____

Primary Registration District No. 3024

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Scott
(b) City or town Sikeston
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(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 one year

3. (a) PRINT FULL NAME Samuel Graves

3. (b) If veteran, name war none 3. (c) Social Security No. _____

4. Sex Male 5. Color or race Colored 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____

7. Birth date of deceased Sept. 3 1871
(Month) (Day) (Year)

8. AGE: Years 74 Months 5 Days 2 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business Farm

12. Name George Graves

13. Birthplace Assisusko Miss.
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

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

16. (a) Informant Edward Graves

(b) Address 209 Westgate Sikeston, Mo.

17. (a) Burial (b) Date thereof 4 6 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sikeston, Mo. 4/6/45

18. (a) Signature of funeral director Mattie Smith

(b) Address 1212 Maud St. Sikeston, Mo.

19. (a) 4/7/45 (b) Louis Largent
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Scott
(c) City or town Sikeston
(If outside city or town limits, write "RURAL")
(d) Street No. 212 Westgate
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 5
year 1945 hour 1:30 minute _____ A.M.

21. I hereby certify that I attended the deceased from 4-3-45 to _____ 1945
that I last saw him alive on 4-3- 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Heart Disease Duration _____
Arteriosclerosis 10 years

Due to _____

Due to _____

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

Major findings: Of operations 93d 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? _____ Means of injury _____

23. Signature W. J. Fernald (M.D. or other)? _____
Address 204 S. Locust St. Sikeston, Mo. 4-2-45

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

1
5
2

RECEIVED

District Health Office No. 2

District File Number 445-614

Date Filed 4/17/45

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.....

Licensed Embalmer No.....

P.O. Address.....

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.