

No. 2
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-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17908

State File No.

FILED JUN 12 1945
Registration District No. 29

Primary Registration District No. 3057

Registrar's No. 33

1. PLACE OF DEATH:

(a) County Ray

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

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

(d) Length of stay: In hospital or institution 90 da.
(Specify whether years, months or days)

In this community all his life

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Ray

(c) City or town Richmond Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. 237 Royal Street
(If rural, give location)

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

If yes, name country u.s.a.

3. (a) PRINT FULL NAME John W. Graham

3. (b) If veteran, name war no.

3. (c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 28th
year 1945 hour one minute 30 a. M.

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 3 years

7. Birth date of deceased March 2nd 1869
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 20 1945 to May 28 1945
that I last saw him alive on May 26 1945
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>	<u>2</u>	<u>3</u>	hr. min.

Immediate cause of death Pneumonia

Due to Pneumonia

Due to

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

10. Usual occupation Farmer

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: Of operations None

Of autopsy None

11. Industry or business Farmer

12. Name James Graham

13. Birthplace Ray Co. Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Subana Coyle

15. Birthplace Ray Co. Mo.
(City, town, or county) (State or foreign country)

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant Winnie Unger

(b) Address Richmond, Mo.

17. (a) burial (b) Date thereof May 29-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Local Chappell

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? _____

18. (a) Signature of funeral director Butch Orest T. H.

(b) Address Richmond Mo.

19. (a) May 30 1944 (b) Mrs. Chas W. Shppard
(Date received local registrar) (Registrar's signature)

While at work? None (Specify type of place) (c) Means of Injury _____

23. Signature G. B. Taylor (M.D. or other) _____
Address Richmond Date signed 5-28-45

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

MOTHER FATHER

12577

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 6/11/45

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 _____

working under my personal supervision.

Registered Apprentice No. _____

Brother's Quest Funeral Home

Signed _____

Louis Quest

Licensed Embalmer No. 4096

P. O. Address _____

Richmond, W.

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. RayRegistrar's No. 338Registration District No. 297Primary Registration District No. 3057

1. PLACE OF DEATH:

- (a) County Ray
 (b) City or town Richmond
 (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)3. (a) PRINT
FULL NAMEJohn W. Graham

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

4. Sex
- m
5. Color or race
- w
6. (a) Single, widowed, married, divorced
- ✓

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

7. Birth date of deceased
- Mar 23
-
- (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
-
- 76
- hr. min.

9. Birthplace
- Ray County Missouri
-
- (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

- MOTHER FATHER { 12. Name.....
 13. Birthplace (City, town, or county) (State or foreign country)
 14. Maiden name.....
 15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant.....
 (b) Address.....
 17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
 (c) Place: burial or cremation.....

18. (a) Signature of funeral director.....
-
- (b) Address.....

19. (a)
- May 30 1945
- (b)
- Mrs. Clara W. Shippard
-
- (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month
- May
- day
- 30
-
- year
- 1945
- hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to....., 19.....
-
- that I last saw him alive on....., 19.....
-
- and that death occurred on the date and hour stated above.
-
- Immediate cause of death.....

Duration

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 sta-
tistically.

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..... (M. D. or other).....
-
- Date signed.....

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

SUPPLEMENTARY

17908