V. S. No. 2
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ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 29 1945

Registration District No. 149

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 19511

Primary Registration District No. 1002

Registrar's No. 2557

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: General Hospital #1 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 1 mo. 4 days (Specify whether years, months or days)
In this community: 6 years

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.: 913 Holmes (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: Vollie Graves
3. (b) If veteran, name war: xx
3. (c) Social Security No.: None
4. Sex: Fe
5. Color or race: Wh
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife: Thomas Daniel Graves
6. (c) Age of husband or wife if alive: xx years
7. Birth date of deceased: March (Month) 1 (Day) 1863 (Year)
8. AGE: Years 82 Months 3 Days 12 If less than one day ____ hr. ____ min.
9. Birthplace: Marshfield (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: At Home
11. Industry or business:
FATHER 12. Name: John Valentine Hoover
FATHER 13. Birthplace: (City, town, or county) Missouri (State or foreign country)
MOTHER 14. Maiden name: Rachel Headley
MOTHER 15. Birthplace: (City, town, or county) Missouri (State or foreign country)
16. (a) Informant: Hospital Records
(b) Address: Kansas City, Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 6-16-45 (Month) (Day) (Year)
(c) Place: burial or cremation: Marshfield, Mo.
18. (a) Signature of funeral director: J. W. Wagner
(b) Address: Kansas City, Mo.
19. (a) 6-15-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 13 year 1945 hour 6 minute 35 A.M.
21. I hereby certify that I attended the deceased from May 9, 1945 to June 13, 1945 that I last saw her alive on June 13, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: lobar pneumonia — Duration
Due to: Fracture of left tibia and fibula caused by fall from 2nd floor window
Due to:
Other conditions: Senility
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

186a-5
18

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): Accident
(b) Date of occurrence: May 9, 1945
(c) Where did injury occur? Kansas City (City or town) Jackson (County) Mo. (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? At Home (Specify type of place)
While at work? No (e) Means of injury: Fall
23. Signature: Clark C. Seely M.D. (M. D. or other)
Address: Fed. Dir. K.C. General Hospital Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 Cecil R. Matthes

Licensed Embalmer No. 3807

P. O. Address Kansas City, 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.