

FILED DEC 17 1946

Registration District No. \_\_\_\_\_

Primary Registration District No. 3026

Registrar's No. 268

1. PLACE OF DEATH:

(a) County Col.  
(b) City or town Jefferson City Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution St. Mary Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 days (Specify whether  
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Warren  
(c) City or town Benson  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME MICHAEL GAIL DE GRAFENREID

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced 3 0

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive 0 years

7. Birth date of deceased 11/30/46 (Month) (Day) (Year)

8. AGE: Years 0 Months 0 Days 2 hr. min.

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

10. Usual occupation M.

11. Industry or business \_\_\_\_\_

12. Name Paul De Graffenreid

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

14. Maiden name Egan Sue De Graffenreid Cum

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

16. (a) Informant Paul De Graffenreid

(b) Address Benson Mo.

17. (a) Burial (b) Date thereof 12-4-46 (Month) (Day) (Year)

(c) Place: burial or cremation New Hope Cemetery

18. (a) Signature of funeral director R. P. Dennis

(b) Address Callaway

19. (a) 12-3-46 (b) R. P. Dennis MD (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 2 year 46. hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 11/30 1946 to 12/2 1946 that I last saw him alive on 12/2/46 and that death occurred on the date and hour stated above.

Immediate cause of death Suffocation  
Due to Congenital atresia of oesophagus.  
Due to \_\_\_\_\_

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

Major findings: Of operations \_\_\_\_\_

Of autopsy: congenital atresia of oesophagus.

22. If death was due to external cause, 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 Paul G. Baker MD (M. D. or other)

Address Jefferson City Mo. Date signed 12/4/46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

4  
Serial Copy # 723.

RECEIVED  
District Health Officer No. 9,  
District File Number  
Date Filed 12-6-56

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.....

*Janis D. Phillips*

....., Registered Apprentice No.....

working under my personal supervision.

Signed *Janis D. Phillips*  
Licensed Embalmer No. *3669*  
P. O. Address *Cedar*

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.