

FILED MAR 31 1947

Primary Registration District No. 4553

1. PLACE OF DEATH:

(a) County WRIGHT  
(b) City or town MANSEFIELD  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 21 DAYS  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME NATHAN ALVIN GRAVES  
3. (b) If veteran, name war NON V  
3. (c) Social Security No. NON V

4. Sex MALE 5. Color or race WHITE  
6. (a) Single, widowed, married, divorced WIDOWED  
6. (b) Name of husband or wife MARTHA S. GRAVES  
6. (c) Age of husband or wife if alive 5 years  
7. Birth date of deceased MAY 5 1866  
(Month) (Day) (Year)

8. AGE: Years 80 Months 9 Days 29  
If less than one day hr. min.

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

10. Usual occupation FARMER

11. Industry or business GRAVES

MOTHER FATHER { 12. Name GRAVES  
13. Birthplace NOT KNOWN  
14. Maiden name NOT KNOWN  
15. Birthplace NOT KNOWN  
(City, town, or county) (State or foreign country)

16. (a) Informant Ethel Gray  
(b) Address Springfield Mo  
17. (a) BURIAL (b) Date thereof MAY 6 - 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation MACOMB Cem.

18. (a) Signature of funeral director J. A. Steffe  
(b) Address MANSEFIELD  
19. (a) 3/6/47 (b) Maline David, Dept.  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County WRIGHT  
(c) City or town MANSEFIELD  
(If outside city or town limits, write "RURAL")  
(d) Street No. 114  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 4  
year 1947 hour 5 minute 10 P.M.  
21. I hereby certify that I attended the deceased from Mar 2 1947 to Mar 4 1947  
that I last saw him alive on Mar 3 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thromb  
Duration 1 day

Due to .....

Due to .....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations CHP  
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?

While at work (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature J. Fusion (M. D. or other) \_\_\_\_\_  
Address Mansefield Date signed 3-6-47

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

RECEIVED  
District Health Officer No. 6,  
District File Number 347-301  
Date Filed MAR 11 1947

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 F.A. Steffe

Licensed Embalmer No. 3221

P. O. Address Manfield, 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.