

FILED NOV 24 1947

Registration District No. 149

Primary Registration District No. 1002

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:
2025 Prospect
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 25 years (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 2025 Prospect 8
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 11

3. (a) PRINT FULL NAME Howard B. Graves

3. (b) If veteran, name war World war 11 3. (c) Social Security No. 498-30-0310

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Frances Graves 6. (c) Age of husband or wife if alive 28 years

7. Birth date of deceased June - 15 - 1922
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
25 4 25 hr. min.

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

10. Usual occupation Porter

11. Industry or business _____

MOTHER FATHER
12. Name Samuel Graves
13. Birthplace Slater, Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Carrington Cason
15. Birthplace Glasgow, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Frances Graves
(b) Address 2025 Prospect

17. (a) Burial (b) Date thereof 11/17/47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St. Leavenworth Natl. Cem.

18. (a) Signature of funeral director E. Sterling Billa
(b) Address 1212 Vine St., Kansas City, Mo.

19. (a) 11-14-47 (b) Heraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10th day Nov.
year 1947 hour 8:20 minute A M.
21. I hereby certify that I attended the deceased from 11-9-47
to 11/10/1947
that I last saw him alive on 11/10 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Pneumonic Phthisis
Duration ?

Due to _____

Due to _____

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

Major findings:
Of operations 138
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) no

(b) Date of occurrence _____

(c) Where did injury occur? _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(e) Means of injury 0
While at work? _____ (Specify type of place)

23. Signature Trutillman (M. D. or other) M.D.
Address 1618 Lydia Date signed 11/3/47

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

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

E. Sterling Bills

Licensed Embalmer No. 3178

P. O. Address 1212 Vine St., K. C., 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.