

No. 300
-10-47
5-17-39
I 3906

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

36555

State File No. _____

FILED DEC 11 1948

4767

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. _____

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

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 No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12 days
(Specify whether years, months or days)

In this community 55 years

3. (a) PRINT FULL NAME John Graf

3. (b) If veteran, name war No

3. (c) Social Security No. None

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 _____ years

7. Birth date of deceased June 8 1864
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>84</u>	<u>5</u>	<u>11</u>	hr. _____ min.

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

10. Usual occupation Stone-cutter

11. Industry or business _____

MOTHER FATHER

12. Name Christian Graf

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

14. Maiden name Catherine Gieger

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

16. (a) Informant Sister Emilie

(b) Address 5331 Highland

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof 11/23/48
(Month) (Day) (Year)

(c) Place: burial or cremation Mt Washington Cemetery

18. (a) Signature of funeral director. Duark, Robin

(b) Address 20 West Linwood

19. (a) 11-22-48
(Date received local registrar)

(b) Thereldine Holmes
(Registrar's signature)

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. 5331 Highland
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Nov. day 19
year 1948 hour 11 minute 5 A. M.

21. I hereby certify that I attended the deceased from Nov. 7, 1948, to Nov. 19, 1948.
that I last saw him alive on Nov. 19, 1948,
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Generalized arteriosclerosis
Terminal bronchopneumonia

Due to _____

Due to _____

Other conditions _____
(include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy None

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?
Wm. W. Hart

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

Signature Wm. W. Hart (M. D. or other) _____

Address Med. Dir. Gen'l Hosp. 11-20-48
Date signed _____

Handwritten scribble

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 Howard W. Farmer

Licensed Embalmer No. 4134

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.