

FILED FEB 21 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4911

342

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>Jackson</u> b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u> c. LENGTH OF STAY (In this place) <u>36 days</u> d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Research Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Ne. Kalb 32</u> c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Mayville</u> d. STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (Type or Print) <u>FRANK William GRAHAM</u> a. (First) b. (Middle) c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 23-1949</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>Jan-10-1867</u>
9. AGE (In years last birthday) <u>82</u> IF UNDER 1 YEAR Months Days IF UNDER 2 WKS. Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Veteran Dr.</u>	
11. KIND OF BUSINESS OR INDUSTRY -		12. BIRTHPLACE (State or foreign country) <u>Ohio-1</u>	
13a. FATHER'S NAME <u>Graham</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	
14. NAME OF HUSBAND OR WIFE <u>Unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs Pearl Jones - N. R.C. Mo. - RFD -</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>accidental injuries (multiple)</u> ANTECEDENT CAUSES <u>multiple rib fractures</u> <u>suspected splenic poleus fractures</u> DUE TO (b) <u>E 816.9</u> DUE TO (c) <u>(3 car collision)</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SOURCE (Specify) <u>Automobile</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.) <u>automobile</u>	21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE) <u>Hiway 169, Clay Co MO 24</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Dec 21, 1946, 7:00 p.m.</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>automobile accident</u>	
22. I hereby certify that I attended the deceased from <u>12/21, 1949</u> , to <u>1/23, 1949</u> , that I last saw the deceased alive on <u>1/23, 1949</u> , and that death occurred at <u>7:30 p.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>I. Charles Fowler M.D.</u> (Degree or title)		23b. ADDRESS <u>2025 Swift Station City, Mo</u>	
23c. DATE SIGNED <u>1/24/49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>Jan-24-1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Mayville Missouri</u>
DATE REC'D BY LOCAL REG. <u>1-24-49</u>		REGISTRAR'S SIGNATURE <u>Geraldine Holmes</u>	
		5. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Mrs. C. R. Foster Funeral Home Kas. City, Mo.</u>	

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

48
18

Signature
John

M. Foster
2025 - Aug 10
M.K.R.

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 _____

.....
working under my personal supervision.

Signed.....
Student Embalmer

Signed *John Stark*
Student Embalmer No. _____

Licensed Embalmer No. *4716*

P. O. Address *Home*

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.