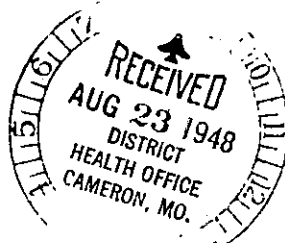


FILED AUG 25 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **29131**

BIRTH NO. _____		REG. DIST. NO. 374		PRIMARY REG. DIST. NO. 4547		Registrar's No. 218	
1. PLACE OF DEATH a. COUNTY Worth				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Worth			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Grant City		c. LENGTH OF STAY (in this place) 7 years		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Grant City			
d. FULL NAME OF HOSPITAL OR INSTITUTION 1				d. STREET ADDRESS (If rural, give location) 0			
3. NAME OF DECEASED (Type or Print) a. (First) Arthur b. (Middle) Roy c. (Last) Graham				4. DATE OF DEATH (Month) (Day) (Year) 8 14 1949			
5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) divorced		8. DATE OF BIRTH May 26 1892	
9. AGE (In years) 57		10. MONTHS 2		11. YEARS 18		12. IF UNDER 14 HRS. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer-day laborer				10b. KIND OF BUSINESS OR INDUSTRY day Laborer		11. BIRTHPLACE (State or foreign country) Afton, Iowa	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13a. FATHER'S NAME Thomas Graham		13b. MOTHER'S MAIDEN NAME Anna Alenson		14. NAME OF HUSBAND OR WIFE Nellie Graham			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. NO		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Naomi Goben Lucas, Iowa			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Paralysis Agitans ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 350A				INTERVAL BETWEEN ONSET AND DEATH 10 years	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES ☐ NO ☒	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov , 19 46 , to Aug 14 , 19 49 , that I last saw the deceased alive on 13 Aug 19 49 and that death occurred at 10 P. M. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Frank B. Mattison, M.D.				23b. ADDRESS Grant City, Mo		23c. DATE SIGNED 8/15/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8 16 1949		24c. NAME OF CEMETERY OR CREMATORY Afton Cemetery		24d. LOCATION (City, town, or county) (State) Afton, Iowa	
DATE REC'D BY LOCAL REG. Aug 17-1949		REGISTRAR'S SIGNATURE Leta E. Dawson		25. FUNERAL DIRECTOR'S SIGNATURE Arch C. Dunfee		ADDRESS Grant City, Mo	



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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed

Arch C. Dunfee

Licensed Embalmer No. 3252

P. O. Address, Grant 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.