

FILED FEB 26 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr. Turner 4452
State File No.
Registrar's No. 136

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000

1. PLACE OF DEATH
a. COUNTY Greene
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield
c. LENGTH OF STAY (in this place) 30 Yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. John Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri b. COUNTY Greene
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield
d. STREET ADDRESS (If rural, give location) 529 Cherry

3. NAME OF DECEASED
a. (First) Elizabeth b. (Middle) _____ c. (Last) Graffius

4. DATE OF DEATH (Month) (Day) (Year)
Feb. 18, 1951

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH May 15 1869

9. AGE (In years last birthday) 81
IF UNDER 1 YEAR: MONTHS _____ DAYS _____
IF UNDER 6 HRS: HOURS _____ MIN. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home

10b. KIND OF BUSINESS OR INDUSTRY HOME

11. BIRTHPLACE (State or foreign country) Adams Co., Ohio

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME William Wykoff

13b. MOTHER'S MAIDEN NAME Harriett Parks

14. NAME OF HUSBAND OR WIFE X

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
Mrs. Farris Nahon Springfield, Mo.

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) BRONCHITIS, ACUTE
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.
ARTERIO SCLEROTIC HEART DIS. & CONGESTIVE FAILURE.

INTERVAL BETWEEN ONSET AND DEATH
3 DAYS

500X

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) _____

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 9/21/49, to 2/18/51, that I last saw the deceased alive on 2/18/51, and that death occurred at 4:25 Pm., from the causes and on the date stated above.

23a. SIGNATURE [Signature] (Degree or title) _____

23b. ADDRESS Springfield, Mo.

23c. DATE SIGNED 2/19/51

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 2-20-51

24c. NAME OF CEMETERY OR CREMATORY UNKNOWN

24d. LOCATION (City, town, or county) (State) KANSAS CITY, MISSOURI

DATE REC'D BY LOCAL REG. 2-20-51

REGISTRAR'S SIGNATURE [Signature]

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
H.H. Lohmeyer Springfield, Mo.

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

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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.

Student Embalmer No.....

Signed *Walter Hamilton*

Signed.....
Student Embalmer

Licensed Embalmer No. *3808*

P. O. Address *Springfield*

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.