

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **15513**
 Registrar's No. **85**

DECEASED JUN 3 1952

REG. DIST. NO. **10** PRIMARY REG. DIST. NO. **3002**

0043

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

1. PLACE OF DEATH a. COUNTY Audrain			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Audrain		
b. CITY (If outside corporate limits, write RURAL and give town or township) Mexico, Missouri		c. LENGTH OF STAY (in this place) 1 day		c. CITY (If outside corporate limits, write RURAL and give township) Mexico, Missouri 0043	
d. FULL NAME OF HOSPITAL OR INSTITUTION Audrain County Hospital			d. STREET ADDRESS (If rural, give location) 615 East Breckenridge		
3. NAME OF DECEASED (Type or Print) a. (First) Oliver		b. (Middle) -		c. (Last) Graves	
4. DATE OF DEATH (Month) (Day) (Year) 5-26-52		5. SEX Male 2		6. COLOR OR RACE Negro	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married		8. DATE OF BIRTH 3/10/1889		9. AGE (In years last birthday) (Months) (Days) (Hours) (Min.) 63	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unable to work		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Robert Graves		13b. MOTHER'S MAIDEN NAME Martha Henderson	
14. NAME OF HUSBAND OR WIFE none		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. -	
17. INFORMANT'S SIGNATURE AND NAME Burt M. Galbreath		17. ADDRESS Route 2 Fulton, Mo.		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) Cerebral hemorrhage	
19. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 14 hrs		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Anterior sclerosis	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 331X		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) no		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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from May 25, 1952 , to May 26, 1952 , that I last saw the deceased alive on May 26, 1952 , and that death occurred at 2:00 A.M. , from the causes and on the date stated above.					
23a. SIGNATURE H. Kallenbach		(Degree or title) M.D.		23b. ADDRESS Mexico, Mo	
23c. DATE SIGNED 5/26/52		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 5-28-1952	
24c. NAME OF CEMETERY OR CREMATORY Old Richland		24d. LOCATION (City, town, or county) (State) Ballouay Co. Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Stuart D. Parker	
25. ADDRESS Columbia, Mo.		DATE REC'D BY LOCAL REG. May 26 52		REGISTRAR'S SIGNATURE Blanche Neely	

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

Student Embalmer No.....
Stuart P. Parke

Licensed Embalmer No. *2900*

P. O. Address *Columbia 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.