

33908

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED NOV 14 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 172 PRIMARY REG. DIST. NO. 4272 Registrar's No. 71

|                                                               |                                   |                                                                                                                                      |                                                                                                                                   |
|---------------------------------------------------------------|-----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Lafayette</u>               |                                   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <u>MO</u> b. COUNTY <u>Carroll</u> |                                                                                                                                   |
| b. CITY OR TOWN <u>Waverly</u>                                | c. LENGTH OF STAY (In this place) | c. CITY OR TOWN <u>Carrollton</u>                                                                                                    | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Kelling Clinic</u> |                                   | e. STREET ADDRESS (If rural, give location) <u>South Main 0111</u>                                                                   |                                                                                                                                   |

|                                     |                           |                      |                         |                                                         |
|-------------------------------------|---------------------------|----------------------|-------------------------|---------------------------------------------------------|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <u>Elvirda</u> | b. (Middle) <u>E</u> | c. (Last) <u>GRAHAM</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>NOV 4 1955</u> |
|-------------------------------------|---------------------------|----------------------|-------------------------|---------------------------------------------------------|

|                      |                               |                                                                                     |                                      |                                           |                                                |                                               |
|----------------------|-------------------------------|-------------------------------------------------------------------------------------|--------------------------------------|-------------------------------------------|------------------------------------------------|-----------------------------------------------|
| 5. SEX <u>female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED, NEVER MARRIED, <sup>9</sup> WIDOWED, DIVORCED, (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>Oct 21, 1872</u> | 9. AGE (In years last birthday) <u>83</u> | IF UNDER 1 YEAR Months <u>-</u> Days <u>13</u> | IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u> |
|----------------------|-------------------------------|-------------------------------------------------------------------------------------|--------------------------------------|-------------------------------------------|------------------------------------------------|-----------------------------------------------|

|                                                                                                              |                                            |                                                                          |                                          |
|--------------------------------------------------------------------------------------------------------------|--------------------------------------------|--------------------------------------------------------------------------|------------------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | 11. BIRTHPLACE (City and State or Foreign Country) <u>Carroll Co. MO</u> | 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u> |
|--------------------------------------------------------------------------------------------------------------|--------------------------------------------|--------------------------------------------------------------------------|------------------------------------------|

|                                        |                                                |                                                 |
|----------------------------------------|------------------------------------------------|-------------------------------------------------|
| 13a. FATHER'S NAME <u>James H Long</u> | 13b. MOTHER'S MAIDEN NAME <u>Sarah Hammond</u> | 14. NAME OF HUSBAND OR WIFE <u>R. M. Graham</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>None</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Chas. Jacobs Bogard</u> | ADDRESS <u>MO</u> |
|--------------------------------------------------------------------------------------------------------------------|-------------------------------------|-------------------------------------------------------------------|-------------------|

|                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                  |  |                                                                         |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br><i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i> | MEDICAL CERTIFICATION                                                                                                                                                                                                                                                            |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>6 days</u><br><br><u>3/13/55</u> |
|                                                                                                                                                                                                                                      | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>uremia</u>                                                                                                                                                                                                             |  |                                                                         |
|                                                                                                                                                                                                                                      | ANTECEDENT CAUSES<br>DUE TO (b) <u>cerebral hemorrhage</u><br><u>arteriosclerosis generalized.</u><br>DUE TO (c) _____<br>II. OTHER SIGNIFICANT CONDITIONS<br><i>Conditions contributing to the death but not related to the disease or condition causing death.</i> <u>331x</u> |  |                                                                         |

|                        |                                  |                                                                                  |
|------------------------|----------------------------------|----------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|------------------------|----------------------------------|----------------------------------------------------------------------------------|

|                                          |                                                                                          |                                                 |
|------------------------------------------|------------------------------------------------------------------------------------------|-------------------------------------------------|
| 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) (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 3/17/55, 19 55, to 11/4, 19 55, that I last saw the deceased alive on 11/4, 1955, and that death occurred at 9:30 Am., from the causes and on the date stated above.

|                                                               |                                       |                                 |
|---------------------------------------------------------------|---------------------------------------|---------------------------------|
| 23a. SIGNATURE (Degree or title) <u>George A Kelling MD C</u> | 23b. ADDRESS <u>Waverly, Missouri</u> | 23c. DATE SIGNED <u>11/5/55</u> |
|---------------------------------------------------------------|---------------------------------------|---------------------------------|

|                                                           |                          |                                                 |                                                                 |
|-----------------------------------------------------------|--------------------------|-------------------------------------------------|-----------------------------------------------------------------|
| 24a. BURIAL OR CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 24b. DATE <u>11-6-55</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Smith</u> | 24d. LOCATION (City, town, or county) (State) <u>Carroll MO</u> |
|-----------------------------------------------------------|--------------------------|-------------------------------------------------|-----------------------------------------------------------------|

|                                              |                                                |                                                   |                                    |
|----------------------------------------------|------------------------------------------------|---------------------------------------------------|------------------------------------|
| DATE REC'D BY LOCAL REG. <u>Nov. 5, 1955</u> | REGISTRAR'S SIGNATURE <u>Clayton W Landrum</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Dickerson</u> | ADDRESS <u>Funeral Home-Bogard</u> |
|----------------------------------------------|------------------------------------------------|---------------------------------------------------|------------------------------------|

(Licensed Embalmer's Statement on Reverse Side)

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

0.300  
0.48

170

ms

DEC 13 1955

**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.....  
Signature of Student Embalmer

Signed.....  
*R. M. Marshall, Jr.*

Licensed Embalmer No. *478*

P. O. Address *Parrott*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.