

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-032696  
STATE FILE NUMBER

73349-50

**FILED OCT 15 1958** Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4546

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>JACKSON</b>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death)<br>a. STATE <b>KANSAS MISSOURI</b> b. COUNTY <b>WYANDOTT WYANDOTT JACKSON</b> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   | c. CITY OR TOWN <b>KANSAS CITY</b> <u>815<sup>th</sup> St</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                 |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>QUEEN OF THE WORLD</b> Length of stay in lb <u>Life</u>   |   | d. STREET ADDRESS (If outside, give location) <u>2738 N. 8th. St.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>                   |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><b>RALPH JOSEPH GRAHAM</b>  |   |   | 4. DATE OF DEATH Month Day Year<br><b>SEPTEMBER 25, 1958</b>                                   |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>NEGRO</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>        | 8. DATE OF BIRTH<br><b>9-24-58</b>   |
| 9. AGE (In years last birthday)  |   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Infant</b>   | 11. BIRTHPLACE (City and state or country)<br><b>KANSAS CITY, MOI</b>                          |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Infant</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY   | 12. CITIZEN OF WHAT COUNTRY?<br><b>NEWBORN</b>   |
| 13. FATHER'S NAME<br><b>Joe Lee Graham</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Donnie Donna Fay Smith</b> <u>2738 N. 8th. St. Kans.</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>Infant</b>   |   | 16. SOCIAL SECURITY NO.<br><b>Infant</b>  | 17. INFORMANT Address<br><b>DONNIE GRAHAM, MOTHER 2738 N. 8th KCK.</b>                         |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>(1) Cerebral hemorrhage Multiple congenital anomalies including hypogenesis of left kidney; bilateral cystic disease of kidney</b> |   |   | INTERVAL BETWEEN ONSET AND DEATH   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____   |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Dislocation of right hip; club feet, deformed ears...</b>   |   |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>7600</b> |   |  |
| 20c. TIME OF INJURY Hour, Month, Day, Year a. m. p. m.   |   |   |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   | 20f. CITY, TOWN, OR LOCATION COUNTY STATE  |
| 21. I attended the deceased from <u>9-21-58</u> to <u>9-25-58</u> and last saw her alive on <u>9-25-58</u><br>Death occurred at <u>8:30 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.                            |   |   |  |
| 22a. SIGNATURE (Degree or title)<br><b>Samuel U. Rodgers M.D.</b>  |   | 22b. ADDRESS<br><b>2462-A Brooklyn</b>  | 22c. DATE SIGNED<br><b>9-26-58</b>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE<br><b>9/27/1958</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westlawn Cemetery</b>  | 23d. LOCATION (City, town, or county) (State)<br><b>Kansas City, Kansas</b>                    |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Mrs. J. W. Jones 440 state ave. Kans.</b>   |   | 25. DATE RECD. BY LOCAL REG.<br><b>9-26-58</b>  | 26. REGISTRAR'S SIGNATURE<br><b>Neva Marshall</b>  |

Health, & Welfare Public Service  
300 1-56  
All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All



STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-  
by me, or by ..... Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Engene English*.....

Licensed Embalmer No. *41*.....

P. O. Address *4400 S. Kansas*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
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.