

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-033195

FILED VS SEP 29 1959 261

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 218

ENDED

1. PLACE OF DEATH a. COUNTY <u>Nodaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Nodaway</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Burlington Jct</u>		Length of stay in 1b <u>79 yr</u>	c. CITY OR TOWN <u>Burlington Jct</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 <u>None</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>_____</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>THOMAS EARL GRAVES</u>			4. DATE OF DEATH Month Day Year <u>Sept 22 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Wh</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 11, 1880</u>	9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>saw mill</u>	11. BIRTHPLACE (City and state or country) <u>Nodaway, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>US</u>	
13a. FATHER'S NAME <u>James Graves</u>		13b. MOTHER'S MAIDEN NAME <u>Eva Dixon</u>		13. NAME OF HUSBAND OR WIFE <u>Lore Thibette Graves</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. _____		17. INFORMANT <u>Mrs Ethel AGENSTEIN</u> Address <u>3016 FARON ST Joseph Mo</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
DUE TO (b) <u>Cerebral arteriosclerosis</u>		<u>?</u>
DUE TO (c) _____		_____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>arteriosclerotic heart disease</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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.) _____
20c. TIME OF INJURY Hour a.m. p.m. _____ Month, Day, Year _____	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 _____, to _____ and last saw her/him alive on _____.
Death occurred at 9/22 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>B. F. Bylund M.D.</u>		22b. ADDRESS <u>Maryville MO</u>		22c. DATE SIGNED <u>9/24/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-24-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ohio Cemetery</u>	23d. LOCATION (City, town, or county) <u>Burlington Jct Mo</u>		
24. FUNERAL DIRECTOR <u>Wm Burlington Jct Mo</u> ADDRESS _____		25. DATE RECD. BY LOCAL REG. <u>9-24-59</u>	26. REGISTRAR'S SIGNATURE <u>Bess Bolt</u>		

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 _____

J. Hann

Licensed Embalmer No. 2968

P. O. Address Burlington, Va.

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.