

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

3230-63-013307
STATE FILE NUMBER

DO NOT WRITE ON THIS STUD

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. _____

FILED MAR 28 1963

1. PLACE OF DEATH a. COUNTY Missouri		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Vernon	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 10 days	c. CITY OR TOWN Nevada Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis-Little Rock Hospital, Inc.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 224 South Lynn Ave. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Eugene Middle Rodney Last Graves			4. DATE OF DEATH Month March Day 18 Year 1963		
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4-8-1914	9. AGE (last birthday) 48	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) conductor		10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (City and state or country) Cherryville, Kansas	12. CITIZEN OF WHAT COUNTRY U.S.	
13a. FATHER'S NAME Arle Graves			13b. MOTHER'S MAIDEN NAME Mabel Stuckey		14. NAME OF HUSBAND OR WIFE Juanita Graves
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date) No			16. SOCIAL SECURITY NO. 860		17. INFORMANT Address Juanita Graves, Nevada, Mo.

18. CAUSE OF DEATH (Enter only one cause)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) *Arteriosclerosis, Heart Disease*
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) *Coronary Arteriosclerosis*
DUE TO (c) *Arteriosclerosis, genl*

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Cardiomegaly - 420.1

PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes No Unknown

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.)
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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 _____
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21. I attended the deceased from **March 9, 1963** to **March 18, 1963** and last saw him alive on **March 18, 1963**
Death occurred at **3:10 P** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)
Charles Knober, M.D.

22b. ADDRESS
St. Louis-Little Rock Hosp. 1755 S. Grand Blvd.

22c. DATE SIGNED
3/19/63

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3-19-63	23c. NAME OF CEMETERY OR CREMATORY Nevada, Mo.	23d. LOCATION (City, town, or county) (State)
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24. FUNERAL DIRECTOR ADDRESS
Hays' Funeral Home, Nevada, Mo.

25. DATE RECD. BY LOCAL REG.
MAR 19 1963

26. REGISTRAR'S SIGNATURE
Loed Smith, M.D.

VS 300 Rev. 4/59
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 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 ITEM NO. SHOULD READ
 USE BLACK INK OR TYPEWRITER RIBBON
 DATE AMENDED
 DOCUMENT
 BY AFFIDAVIT OF

MISSOURI

DEPT. OF HEALTH

APR 1 1963

MAY 27 1963

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 Harvey Kahle

Licensed Embalmer No. 4596

P. O. Address St. Louis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.