

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

18204

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township Kaw Primary Registration District No. 1002
City Kansas City (No. 3810 Troost Avenue) St. _____ Ward _____

File No. _____
Registered No. 2249
St. _____ Ward _____

2. FULL NAME Edward G. Gravelle

(a) Residence. No. 3810 Troost Avenue St. 13 Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Edith Gravelle

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 5, 1879

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
49 5 10

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Druggist
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Kansas

10. NAME OF FATHER Edward Gravelle

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Kansas

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) not known

14. INFORMANT Mrs. Edith Gravelle
(Address) 3810 Troost Ave.

15. FILED 5/16, 1929 M. M. Crowe
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 15, 1929

17. I HEREBY CERTIFY, That I attended deceased from April 26, 1929 to May 15, 1929 that I last saw him alive on May 15, 1929 and that death occurred, on the date stated above, at 11:15 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Organic Heart Disease
(1) Myocardial Infarction (2) Myocard
Regurgitation
95B (duration) yrs. 8 mos. ds.

CONTRIBUTORY (SECONDARY) Influenza 1918
(duration) yrs. N mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) E. Monahan, M. D.
5/16, 1929 (Address) 311 Cassley Alley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENCE CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Forest Hill Cemetery 5-17 1929

20. UNDERTAKER Stine + McOlure ADDRESS 3235 Killebrew Plaza

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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