

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

Do not use this space.

1336

1. PLACE OF DEATH

County quincy

Registration District No. _____

Township Law

Primary Registration District No. _____

City Kansas City (No. Genl Hosp #2)

File No. _____

Registered No. 157

St. _____

Ward) _____

2. FULL NAME

(a) Residence No. 2440 Floral county 7th St., 4 Ward.

(Usual place of abode)

Ward.

(If nonresident, give city or town and State)

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

colored

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

married

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

Ediza Graves

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

Aug 15, 1852

7. AGE

YEARS

78

MONTHS

4

DAYS

25

If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

none

(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)

unknown, mo

10. NAME OF FATHER

Lindley Graves

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

Unknown, Ky

12. MAIDEN NAME OF MOTHER

Ediza Ank

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

Ky

14. INFORMANT (Address)

Record Clerk Genl Hosp #2

15. FILED

7/13 1931

M. M. Brewer

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-10-1931

17.

I HEREBY CERTIFY, That I attended deceased from

11-2-, 1931, to 1-10, 1931

that I last saw him alive on 1-10, 1931, and that death occurred, on the date stated above, at 2:25 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

lobar pneumonia

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY)

the myocarditis

(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH unknown

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS

Autopsy

(Signed) D. M. Miller, M. D.

1/11 1931 (Address) Gen Hosp #2

*State the DISEASE CAUSING DEATH, or in deaths from VIOLEN: 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

Blueledge Lawn Cemetery 1-13 1931

20. UNDERTAKER

ADDRESS

Julius C. Fickler 1212 Union

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

