

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

35577
Do not use this space.

1. PLACE OF DEATH
 (a) County Buchanan Registration District No. 6
 (b) Township St. Joseph Primary Registration District No. 1107
 (c) City St. Joseph (d) Street No. St. Joseph's Hospital Registered No. 1098
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME SAMUEL LEON GRAVIN
 (a) Residence, No. 36 Park St. Brookline, Mass. St. Brookline, Mass.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX MALE 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Divorced

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day,hrs. ormin.
<u>Est 61</u>	<u>?</u>	<u>?</u>	<u>?</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. SALESMAN
 9. Industry or business in which work was done, as saw mill, bank, etc. Dry Goods
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Prussia GERMANY 10

FATHER

13. NAME Unknown
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) " "

MOTHER

15. MAIDEN NAME Unknown
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) " "

17. INFORMANT (ADDRESS) ESTELL DAVIDOFF 26 PARK ST. BROOKLINE MASS

18. BURIAL, CREMATION, OR REMOVAL PLACE BROOKLINE, MASS. DATE Oct. 25th 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) FLEEMAN & SON, INC. 1946 Calhoun St. Joseph, Mo.

20. FILED 10/26 1939 W. B. Post Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-24 1939

22. I HEREBY CERTIFY, That I attended deceased from 10-23 1939 to 10-24 1939
 I last saw him alive on 10-24 1939. Death is said to have occurred on the date stated above, at 7:20 P.M.
 The principal cause of death and related causes of importance were as follows:
Cerebral Haemorrhage
Possible terminal Pneumonia
 Other contributory causes of importance:
Possible terminal Pneumonia

Date of onset 10-23-39

Name of operation None Date of 10-24-39
 What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury....., 19.....
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify Wm B. Post, M. D.
 (Signed) Wm B. Post
 (Address) St. Joseph, Mo.

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.

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INDUSTRIAL STATE OFFICE
INDEX CARD RETURNED TO DISTRICT
DATE 1/11/59

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

C. G. Swan

Licensed Embalmer No. 4683

P. O. Address St. Joseph, 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 this body is not embalmed, above space should be left blank.