

Registration District No. 486 Primary Registration District No. 4293

NOV 20 1940

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.

1. PLACE OF DEATH:
(a) County Lincoln
(b) City or town Elsterny
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days) (Specify whether
years, months or days)

3. (a) PRINT FULL NAME James Wesley Graves
8. (b) If veteran, name war _____ (c) Social Security No. _____
4. Sex male 5. Color or race White 6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife Sally Graves 6. (c) Age of husband or wife if alive 78
7. Birth date of deceased Oct. 26 1858
(Month) (Day) (Year)

8. AGE: Years 82 Months 11 Days 16 If less than one day (hr. min.)

9. Birthplace VA (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business
MOTHER FATHER { 12. Name Robert Presley Graves
13. Birthplace VA (City, town, or county) (State or foreign country)
14. Maiden name Mary Fletcher
15. Birthplace VA (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs A R Knorr
(b) Address 507 1/2 Allen St. Louisiana

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 14 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Eolia Mo

18. (a) Signature of funeral director W W Bradley
(b) Address Elsterny Mo

19. (a) Oct 11-16-40 (Date received local registrar) (b) Etta Powell (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Lincoln
(c) City or town Elsterny (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct day 12 year 1940 hour 10 minute 100 A M
21. I hereby certify that I attended the deceased from Sept 21-1940 to Oct 11-1940
that I last saw him alive on Oct 11-1940 and that death occurred on the date and hour stated above.

Immediate cause of death State's Commission
Stroke - Right Side
Duration _____
Due to Injury to neck from
falling over horse
not captured to bed
Other conditions (Include pregnancy within 3 months of death)
Major findings: _____
Of operations _____
Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence Sept 21-1940
(c) Where did injury occur? at home (City or town) (County) (State)
(d) Did injury occur in or about home, or in industrial place, or in public place? at home

(Specify type of place) _____
While at work? _____ (b) Means of injury _____

23. Signature W. J. ... (M. D. or other) _____
Address Elsterny, Mo Date signed 10-14-40

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..... *W.D. Bradley*.....

Licensed Embalmer No. *3966*.....

P. O. Address..... *Essex, 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.