DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 7 1942

Registration District No. 42

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

33220

State File No.

Primary Registration District No. 1000

Registrar's No. 825

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Sisters O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 days
(Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County DeKalb

(c) City or town Union Star
(If outside city or town limits write "RURAL")

(d) Street No. Route #2
(If rural, give location)

(e) If foreign born, how long in U. S. A.? / years.

8. (a) PRINT FULL NAME Bessie Marie Graves

8. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife Vernon Graves.

6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased March (Month) 27 (Day) 1906 (Year)

8. AGE: Years	Months	Days	If less than one day
37	7	4	hr. min.

9. Birthplace Stewartsville (City, town, or county) Mo O (State or foreign country)

10. Usual occupation housewife

11. Industry or business

MOTHER FATHER

12. Name John Ball

13. Birthplace Mo (City, town, or county) Mo O (State or foreign country)

14. Maiden name Mary Beers

15. Birthplace (City, town, or county) Mo O (State or foreign country)

16. (a) Informant V D Graves Husband

(b) Address Union Star Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-3-42 (Month) (Day) (Year)

(c) Place: burial or cremation Union Star

18. (a) Signature of funeral director John G Brann

(b) Address Cameron Mo

19. (a) 11-3-42 (Date received local registrar) (b) Roe Hezog (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 28

year hour minute M.

21. I hereby certify that I attended the deceased from Oct 23, 1942, to Oct 31, 1942; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Puerperal Sepsis (Strep).	4 days.
Due to Caesarean opp followed by ray exposure	
Due to	
Other conditions (Include pregnancy within 3 months of death) Carcinoma pelvis	
Major findings: Of operations prolonged labor. ray exposure	
Of autopsy Done.	

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

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)

While at work (e) Means of injury

23. Signature Ben H Sheridan (M. D. or other)

Address 620 Francis Date signed 11-4-42

12.50 (Licensed Embalmer's Statement on Reverse Side)

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 me

, Registered Apprentice No.

working under my personal supervision.

Signed John G Brown

Licensed Embalmer No. 3933

P. O. Address Clarksdale Miss

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.

S. No. 2B
—8-21-41
X29288

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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St Joseph (If outside city or town limits, write "RURAL" and name of township)

(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 years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Bessie Maud Graves

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased March 27 (Month) (Day) 1905 (Year)

8. AGE: Years 37 Months 7 Days If less than one day hrs. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. Day 31 year 1942 hour 9 minute 05 A. M.

21. I hereby certify that I attended the deceased from Oct 31, 1942, that I last saw h[illegible] alive on Oct 31, 1942, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
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

(c) Where did injury occur? (City or town) (County) (State)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY