

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 693

FILED SEP 10 1943 128  
Registration District No. \_\_\_\_\_

Primary Registration District No. 2000

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

1. PLACE OF DEATH:  
(a) County GREENE  
(b) City or town Springfield  
(c) Name of hospital or institution: 2406 E. Avenue 1  
(d) Length of stay: In hospital or institution  
In this community all his life

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Greene  
(c) City or town Springfield  
(d) Street No. 2406 Eastline  
(e) If foreign born, how long in U. S. A? 0 years.

3. (a) PRINT FULL NAME THOMAS JOEL GRAVES  
(b) If veteran, name war no  
(c) Social Security No. no

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Aug day 24  
year 1943 hour 7 minute 30 P.M.

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife ALLIE ANN GRAVES  
6. (c) Age of husband or wife if alive 77 years  
7. Birth date of deceased Oct 25 1865

21. I hereby certify that I attended the deceased from 8-10 1943 to 8-24 1943  
that I last saw him alive on 8-23 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardio-renal vascular  
depression Duration 2 WK.

8. AGE: Years 77 Months 9 Days 29  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) 13 10

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

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

10. Usual occupation Farmer  
11. Industry or business Farmer  
12. Name Michael Graves  
13. Birthplace Ind. Indiana  
14. Maiden name Doris Kimmons  
15. Birthplace Ind. Unknown

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? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

16. (a) Informant Wm T Graves  
(b) Address 8216 Taylor Ave, Spfld, Mo  
17. (a) Burial (b) Date thereof Aug 26 43  
(c) Place: burial or cremation Wade Chapel  
18. (a) Signature of funeral director Wm T Graves  
(b) Address Springfield Mo  
19. (a) 8-26-43 (b) W E Handley

While at work? \_\_\_\_\_  
23. Signature Max J. [unclear] (M. D. or other) MO  
Address Springfield Mo Date signed 8-25-43

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**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 *Roy A. Lavin*.....

Licensed Embalmer No. *1763*.....

P. O. Address *Springfield, 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, fact should be so stated above.**

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