No. 300
10-48

FILED SEP 19 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29571

BIRTH NO. _____ REG. DIST. NO. 131 PRIMARY REG. DIST. NO. 3023 Registrar's No. 23

1. PLACE OF DEATH
a. COUNTY Henry
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Clinton
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo
b. COUNTY Henry
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Urich
d. STREET ADDRESS (If rural, give location) 420

3. NAME OF DECEASED (Type or Print) a. (First) Dorothe b. (Middle) Dean c. (Last) Graef

4. DATE OF DEATH (Month) 9 (Day) 8 (Year) 1955

5. SEX Fmale

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH Sept 11-1920

9. AGE (In years last birthday) 34 IF UNDER 1 YEAR Months 11 Days 28 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY Housewife

11. BIRTHPLACE (City and State or Foreign Country) Okla. City - Okla.

12. CITIZEN OF WHAT COUNTRY? U.S. A.

13a. FATHER'S NAME Walter A. Jones

13b. MOTHER'S MAIDEN NAME Vina Lillian Todd

14. NAME OF HUSBAND OR WIFE Wm F. Graef

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 445-26-0767

17. INFORMANT'S SIGNATURE OR NAME ADDRESS W. F. Graef Urich MO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	MYOCARDITIS	2 WK
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.	NEPHRO-SCLEROSIS DIABETES	2 YR 20 YR

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION 4222

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) NO

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1950, *to* Sept 8, 1955, *that I last saw the deceased alive on* Sept 8, 1955, *and that death occurred at* 11:15A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Hugh B. Walker, MD

23b. ADDRESS Clinton, Mo

23c. DATE SIGNED 10 Sept 1955

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Sept-11-1955

24c. NAME OF CEMETERY OR CREMATORY Mullins Cem.

24d. LOCATION (City, town, or county) Near Urich (State) MO

DATE REC'D BY LOCAL REG. Sept 11-1955

REGISTRAR'S SIGNATURE Florence Adair

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wade Brown Urich MO

(Licensed Embalmer's Statement on Reverse Side)

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

SEP 2 [illegible] 1955

MAY 17 1956

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.....

..... Student Embalmer No. .....,

working under my personal supervision.

Student .....
Student Embalmer

Signed R. R. Kennedy

Licensed Embalmer No. 3099

P. O. Address Clinton 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, fact should be so stated above.