

FILED JAN 21 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1948

BIRTH NO. _____		REG. DIST. NO. <u>187</u>		PRIMARY REG. DIST. NO. <u>5701</u>		State File No. <u>3040</u>		Registrar's No. <u>36</u>			
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).							
a. COUNTY <u>Livingston</u>				a. STATE <u>Missouri</u>		b. COUNTY <u>Livingston</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Chula</u>		c. LENGTH OF STAY (in this place) township) <u>11 years</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Chula</u>		0590					
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Emmanuel Catholic Hospital</u>				d. STREET ADDRESS (If rural, give location) <input checked="" type="checkbox"/>							
3. NAME OF DECEASED			4. DATE OF DEATH			5. SEX			6. COLOR OR RACE		
a. (First) <u>John</u>			b. (Middle) <u>William</u>			c. (Last) <u>Graves</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>January 5 1957</u>		
(Type or Print)											
5. SEX <u>Male</u>			6. COLOR OR RACE <u>White</u>			7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>			8. DATE OF BIRTH <u>April 12 1872</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>			9. AGE (In years last birthday) <u>84</u>			11. BIRTHPLACE (State or foreign country) <u>Livingston Co Missouri</u>		
11. BIRTHPLACE (State or foreign country) <u>Livingston Co Missouri</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13a. FATHER'S NAME <u>George Graves</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Street</u>		
14. NAME OF HUSBAND OR WIFE <u>Margaret Graves</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. John Graves Chula</u>		
18. CAUSE OF DEATH			MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH		
Enter only one cause per line for (a), (b), and (c)			I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Paralytic ileus</u>						36 hrs		
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.			ANTECEDENT CAUSES						36 hrs		
			DUE TO (b) <u>Fecal impaction</u>								
			DUE TO (c) <u>arteriosclerosis, myocarditis, asthma</u>						20 yrs		
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify)			21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			5701		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)			21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>Aug</u> , 19 <u>54</u> , to <u>Jan 5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 5</u> , 19 <u>57</u> , and that death occurred at <u>6:00</u> m., from the causes and on the date stated above.											
23a. SIGNATURE (Degree or title) <u>Thomas L. Milazzo DO.</u>				23b. ADDRESS <u>Chillicothe</u>				23c. DATE SIGNED <u>1-5-57</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Jan 7 1957</u>		24c. NAME OF CEMETERY OR CREMATORY <u>St Columbian Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Chillicothe Mo</u>					
DATE REC'D BY LOCAL REG. <u>1-5-57</u>			REGISTRAR'S SIGNATURE <u>Frances B. Neill</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>E.J. Robertson Funeral Home Chula MO</u>					

(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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *J. Robertson*

Licensed Embalmer No. *4388*

P. O. Address *Laredo, Tex*

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.