Health, Welfare Public Service

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-008132
STATE FILE NUMBER

FILED MAR 4 1959 Registration District No. 347 Primary Registration District No. 6162 Registrar's No. 8

1. PLACE OF DEATH
a. COUNTY Stone
b. CITY OR TOWN Reeds Spring — Inside Limits Yes ☐ No ☒
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY Stone
c. CITY OR TOWN Reeds Spring Mo — Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: JACKIE Middle: RAY Last: GRAVES
4. DATE OF DEATH Month: Feb Day: 9 Year: 1959
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Feb 9 1959
9. AGE (In years last birthday) — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours 1, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Reeds Spring Mo
12. CITIZEN OF WHAT COUNTRY? U S A
13a. FATHER'S NAME Billy Joe Graves
13b. MOTHER'S MAIDEN NAME Martha Sue Keyser
14. NAME OF HUSBAND OR WIFE
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.
17. INFORMANT Joe Graves Address Reeds Spring Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Failure of foramin ovale to close — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Don't Know
DUE TO (c) Don't Know
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 7543
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Feb 9 1959 to Feb 9 1959 and last saw him alive on Feb 9 1959
Death occurred on 6 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE L S Shumate (Degree or title) MD
22b. ADDRESS Reeds Spring Mo
22c. DATE SIGNED 2/9/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE Feb 10 1959
23c. NAME OF CEMETERY OR CREMATORY Yocum Pond Cemetery
23d. LOCATION (City, town, or county) Reeds Spring Mo (State)

24. FUNERAL DIRECTOR Everett Chenault ADDRESS Salem Mo
25. DATE RECD. BY LOCAL REG. Feb. 12-59
26. REGISTRAR'S SIGNATURE Mrs J Elmer Brown

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was not embalmed by me, or by ....., Student Embalmer No. ..... working under my personal supervision.

Student ..... Signature of Student Embalmer

Signed Everett J. Cheatham

Licensed Embalmer No. 3870

P. O. Address Galena, Kx

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.