

FEDERAL BUREAU OF INVESTIGATION FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-036007

FILED VS. OCT 26 1959 / 40

Registration District No. _____

Primary Registration District No. 3024

Registrar's No. 90

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Howard</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howard</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fayette</u>		Length of stay in 1b <u>11 months</u>		c. CITY OR TOWN <u>Fayette</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Shields Nurseing Home</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>306 South Main</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Arthur</u> First Middle Last <u>Gravitt</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>20</u> Year <u>1959</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>6/2/1883</u>	9. AGE (last birthday) <u>76</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (City and state or country) <u>Howard Co.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>David Crockett Gravitt</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Bell Creed</u>			14. NAME OF HUSBAND OR WIFE <u>Cora Melisa Robert</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>500-20-2047</u>		17. INFORMANT Address <u>Ona Bella Zornes Columbia Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of prostate & metastasis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)					
20c. TIME OF INJURY - Hour _____ m. _____ p.m. Month, Day, Year _____								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			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 <u>June 1958</u> to <u>Oct 20-1959</u> and last saw her/him alive on <u>Oct 19-59</u> . Death occurred at <u>306 South Main</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>Wm J Shaw</u> (Degree or title) <u>M.D.</u>					22b. ADDRESS <u>Fayette, Mo.</u>		22c. DATE SIGNED <u>10-22-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10/23/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem.</u>			23d. LOCATION (City, town, or county) (State) <u>Columbia Missouri</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Ralph A. Carr Fayette Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>10-22-59</u>		26. REGISTRAR'S SIGNATURE <u>Katherine Welch</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS OCT 28 1959 SA

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 _____
Signature of Student Embalmer

Signed William E. Kreber

Licensed Embalmer No. 4870

P. O. Address Hayette M

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.