

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-008672

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2028

DO NOT WRITE ON THIS STUB  
AMENDED

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cape Girardeau</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MO.</u>		c. CITY OR TOWN <u>Jackson</u>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSP #L</u>		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARENCE GRAVES</u>		4. DATE OF DEATH Month Day Year <u>2 22 63</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/12/1875</u>
9. AGE (last birthday) <u>88</u>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factory worker - Iapplier - Sawyer Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Indiana</u>	
11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James Graves</u>		13b. MOTHER'S MAIDEN NAME <u>Mary (Unknown)</u>	
14. NAME OF HUSBAND OR WIFE <u>Ella T. Graves</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of servi <u>No</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Carol Johnson 58pl Ridge Ave</u>	
18. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive Heart failure</u>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Disease</u>			
DUE TO (c) <u>Generalized severe Arteriosclerosis.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>chronic cholecystitis</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 a.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>2-12-63</u> to <u>2-22-63</u> and last saw her/him alive on <u>2-22-63</u> . Death occurred at <u>2:20 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>W. E. Cozart M.D.</u> (Degree or title)		22b. ADDRESS <u>1515 LAFAYETTE AVE.</u>	22c. DATE SIGNED <u>2-22-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal (Auto)</u>	23b. DATE <u>2/23/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Russell Heights Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Jackson, Missouri</u>
24. FUNERAL DIRECTOR <u>Cracraft - Miller Funeral Home</u>		25. DATE RECD. BY LOCAL REG. <u>FEB 25 1963</u>	26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>

D. E. Cozart, M.D.  
USE BLACK INK OR TYPEWRITER RIBBON

**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 J. Allen Davis Jr

Licensed Embalmer No. 4053

P. O. Address St. Louis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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