

STANDARD CERTIFICATE OF DEATH

State File No. **31362**

Registration District No. **10**

Primary Registration District No. **5105**

Registrar's No. **37**

REC'D OCT 11 1940

1. PLACE OF DEATH:

(a) County **Bollinger**
(b) City or town **Zalma**
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2**
In this community **All her life** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Arla Jane Grimes,**

3. (b) If veteran, name war. _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **W** 6. (a) Single, widowed, married, divorced. **Married**

6. (b) Name of husband or wife **E. O. Grimes,** 6. (c) Age of husband or wife if alive **67** years

7. Birth date of deceased **Nov 9th 1881**
(Month) (Day) (Year)

8. AGE: Years **58 59** Months **9** Days **21** If less than one day hr. _____ min. _____

9. Birthplace **Zalma, Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **House Keeper**

11. Industry or business _____

12. Name **Mahlan Cox**

18. Birthplace **Zalma, Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name **Emeline Louis Ind**

15. Birthplace **Ind**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Paula Grimsley**

(b) Address **Parma, Mo.**

17. (a) **Burial** (b) Date thereof **Sept 1st**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Brush Creek**

18. (a) Signature of funeral director **Robert Funeral Home**

(b) Address **Lutasville, Mo.**

19. (a) **9/2-40** (b) **Mrs. J. E. Berry**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Bollinger**
(c) City or town **Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **Near Zalma, Mo.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **30th**
year **1940** hour **7:00** minute **20** A. M.

21. I hereby certify that I attended the deceased from **Aug 24, 1940**
to **Aug 29, 1940**
that I last saw him alive on **Aug 28, 1940**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage**
Duration **8-21-40 to 8-28-40**

Due to **Arterio-Sclerosis**

Due to _____

Other conditions **gfh**
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? **70**

(Specify type of place) _____
(e) Means of injury _____

23. Signature **Dr. Edward Ford** (M. D.)
Address **Parma, Mo.** Date signed _____

WHILE PRINTING USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very impor

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.....

....., Registered Apprentice No.

.....
working under my personal supervision.

Signed

J. E. Graham

Licensed Embalmer No. *4010*

P. O. Address *Luttrellville*

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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **31362**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **69**

Primary Registration District No. **5108**

Registrar's No.

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

1. PLACE OF BIRTH:

(a) County **Bollinger**
(b) City or town **Wayne**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ (Specify whether)
years, months or days

3. (a) PRINT FULL NAME **Arla Jane Grimes**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **m**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased **Nov 9 1881**
(Month) (Day) (Year)

8. AGE: Years **58 = 39** Months **9** Days **21** If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **1218** (Date received local registrar) (b) **Mrs. Jake Berry** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **30** year **1946** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____ that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____ (e) Means of injury _____

23. Signature **Edgar Ford** (M. D. or other) _____

Address **Carroll** Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

