

STANDARD CERTIFICATE OF DEATH

FILED OCT 18 1940

Registration District No. **548**

Primary Registration District No. **5740**

Registrar's No. **47**

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

1. PLACE OF DEATH:

(a) County Marion
(b) City or town Palmyra
(c) Name of hospital or institution:
West part of City of Palmyra
(d) Length of stay: In hospital or institution four months
In this community four months

3. (a) PRINT FULL NAME Elizabeth Belle Griswold

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

4. Sex female 5. Color or race white
6. (a) Single, widowed, married, divorced widow
6. (b) Name of husband or wife F.R. Griswold
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased May 6 1862

8. AGE: Years 78 Months 4 Days 19 If less than one day _____ hr. _____ min.

9. Birthplace Emerson Mo.

10. Usual occupation house wife

11. Industry or business _____

12. Name George Waller
13. Birthplace Bavaria Germany

14. Maiden name Elmora Johnson
15. Birthplace Quincy Ill

16. (a) Informant Russel Griswold
(b) Address Ewing Mo

17. (a) burial (b) Date thereof Sept 22 1940
(c) Place: burial or cremation Gilead Cemetery

18. (a) Signature of funeral director Thamos Ball
(b) Address Ewing Mo 480

19. (a) Sept 22 1940 (b) Gertrude Lee
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lewis
(c) City or town Ewing
(d) Street No. RFD. 3.
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 20
year 1940 hour 7 minute 15 P.M.

21. I hereby certify that I attended the deceased from May 29th 1940 to Sept 20 1940
that I last saw her alive on Sept 20 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Paralysis
Due to Paralysis

Other conditions None
(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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

23. Signature Dr. J. B. Mess (M. D. or other) _____
Address Palmyra Mo Date signed 9/23/40

Duration 1940
PHYSICIAN
Underline the cause to which death should be charged statistically.

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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 Thomas Ball

Licensed Embalmer No. 1744

P. O. Address.....

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. **32557**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **348**

Primary Registration District No. **5740**

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County **Marion**
(b) City or town **Liberty, T. P.**
(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

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.

3. (a) PRINT FULL NAME

Elizabeth Belle Groswood

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 **wid**
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years
7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years **78** Months **4** Days **19** If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **20th**
year **1950** hour _____ minute _____ M.

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

Immediate cause of death **Hemiplegia** Duration _____

Due to **Thrombosis**

Due to _____

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

Major findings: _____ Of operations _____

Of autopsy **was long in waiting care transferred to my care** **82 B**

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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTAL COPY

