

MAILED JAN 10 1947

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **41439**

**4832**

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
2523 Lawn St.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community Life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City,  
(If outside city or town limit, write "RURAL")  
(d) Street No. 2523 Lawn (If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 18  
year 1940 hour 5 minute 20 A. M.

21. I hereby certify that I attended the deceased from Aug 20 to Dec 18, 1940  
that I last saw her alive on Dec 17, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Ch. Myocardial Infarction & Valvular Disease  
Due to Generalized Arterio Sclerosis  
Due to Ch. Bright's Disease

Duration

Other conditions 131  
(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?  
361 (Specify type of place)  
While at work?  (e) Means of injury

23. Signature D. E. Leonard (M. D. or other)  
Address 4800 E. 44th Date signed 12/18/40

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

3. (a) PRINT FULL NAME Elizabeth Catherine Grimes

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Charles C. Grimes 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Sept 6 1860  
(Month) (Day) (Year)

8. AGE: Years 80 Months 3 Days 4 12 If less than one day  
hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

11. Industry or business Same

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. Ethel McPhenson

(b) Address 6419 E. 15th St Terr, K.C. Mo.

17. (a) Burial (b) Date thereof Dec. 20th,  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hamilton, Missouri

18. (a) Signature of funeral director Rose & Henderson

(b) Address Kansas City, Missouri

19. (a) 12-20-40 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

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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.....

*John B. Camp*

Licensed Embalmer No. ....

*29355*

P. O. Address.....

*P. C. 910*

**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.**