

Registration District No. **15**

Primary Registration District No. **4327**

1. PLACE OF DEATH: *Miller*  
(a) County *Iberia*  
(b) City or town *Iberia*  
(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 *Life* years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State *Mo.* (b) County *Miller 66*  
(c) City or town *Iberia*  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? *no* (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME *SARAH JANE GRADY*  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month *Aug.* day *30*  
year *1943* hour *9* minute *30 P.* M.  
21. I hereby certify that I attended the deceased from *August 30*  
19*43*, to *August 30* 19*43*  
that I last saw h*er* alive on *August 30* 19*43*  
and that death occurred on the date and hour stated above.

4. Sex *Female* 5. Color or race *white*  
6. (a) Single, widowed, married, divorced *Married*  
(b) Name of husband or wife *Thomas J. Grady* alive *80* years  
7. Birth date of deceased *Aug - 26 1864*  
(Month) (Day) (Year)

Immediate cause of death *Myocardial Failure*  
Due to *Chronic Myocarditis*  
Due to \_\_\_\_\_

8. AGE: Years *79* Months \_\_\_\_\_ Days *4*  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Other conditions *Lobar Pneumonia*  
(Include pregnancy within 3 months of death)  
Duration *3 days*

9. Birthplace *Iberia Mo 0*  
(City, town, or county) (State or foreign country)  
10. Usual occupation *Housekeeper*  
11. Industry or business *Farm*

Major findings: Of operations \_\_\_\_\_  
Of autopsy *108*  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER  
12. Name *James James*  
13. Birthplace *Kentucky 1*  
(City, town, or county) (State or foreign country)  
14. Maiden name *Francis Bolin*  
15. Birthplace *Virginia 1*  
(City, town, or county) (State or foreign country)  
16. (a) Informant *Walter Grady*  
(b) Address *Iberia Mo.*  
17. (a) *Burial* (b) Date thereof *9-1-43*  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation *Imperial Cemetery, Hancock, Mo.*  
18. (a) Signature of funeral director *W. L. Conroy*  
(b) Address *Iberia Mo.*  
19. (a) *Sept 4-43* (b) *Jessie Perkins*  
(Date received local registrar) (Registrar's signature)

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) Means of injury \_\_\_\_\_  
23. Signature *Wm. A. Gould* (M. D. or other) *DO*  
Address *Iberia Mo* Date signed *9/4/43*

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

RECEIVED

Miller County Health Dep't.

County File Number... 43-66

Date Filed 9-7-49

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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 Ch Bacey  
Licensed Embalmer No. 2694  
P. O. Address Iberia 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 this body is not embalmed, fact should be so stated above.**