

FILED FEB. 27 1948

State File No.

Registration District No.

Primary Registration District No. 3000

Registrar's No. 53

1. PLACE OF DEATH:

(a) County Adair
 (b) City or town Kirksville
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Community Nursing Home #2 4
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 4 Mo. 9 days
 (Specify whether years, months or days)
 In this community 4 Mo. 9 days

3. (a) PRINT FULL NAME Charles A. Gristy

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Sarah Gristy 6. (c) Age of husband or wife if alive several years
 7. Birth date of deceased: JUNE 12 1863
 (Month) (Day) (Year)

8. AGE: Years 84 Months 8 Days 3 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER { 12. Name Simon Gristy
 13. Birthplace Missouri
 14. Maiden name Harriet O'Brien
 15. Birthplace Ky.
 (City, town, or county) (State or foreign country)

16. (a) Informant Joseph Rhodes

(b) Address Blountfield, Iowa

17. (a) Removal (b) Date thereof 2-15-1948
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director W. W. Wagner

(b) Address Blountfield, Iowa

19. (a) 2-16-48 (b) Kate Lambert
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Schuyler 98
 (c) City or town Downing
 (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 15
 year 1948 hour 4:00 minute 30 P.M.

21. I hereby certify that I attended the deceased from Oct 6 1947 to Feb 15 1948
 that I last saw him alive on Feb 15 1948
 and that death occurred on the date and hour stated above.

Immediate cause of death: Acute Circulatory Failure
 Due to Myocardial Degeneration
 Due to Arteriosclerosis

Other conditions Paralysis Agitans
 (Include pregnancy within 3 months of death)

Major findings: 99P
 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?

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

23. Signature G. H. Throgm (M. D. or other) DO
 Address Kirksville Mo Date signed 2-15-48

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

RECORDED
District Health Officer No. 10
District File Number 2-48-261
DEC 25 1948

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 myself
....., Registered Apprentice No.
working under my personal supervision.

Signed [Signature]
Licensed Embalmer No. 3554
P. O. Address Bloomfield, N.J.

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.