No. 2
-1/47
-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED OCT 15 1948

Registration District No. .....

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3041

State File No. 30350

Registrar's No. 381

1. PLACE OF DEATH:
(a) County Macon
(b) City or town Macon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 317 E. 3rd. St. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Macon 61
(c) City or town Macon 3
(If outside city or town limits, write "RURAL")
(d) Street No. 317 E. 3rd. St. 2
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No) U
If yes, name country No.

3. (a) PRINT FULL NAME William Grant
3. (b) If veteran, name war .....
3. (c) Social Security No. 489-12-9824

4. Sex Male
5. Color or race Negro
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Zenobia Grant
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased June (Month) 20, (Day) 1861 (Year)

8. AGE: Years	Months	Days	If less than one day
77	3	1	....hr. ....min.

9. Birthplace Macon (City, town, or county) Mo. (State or foreign country) U
10. Usual occupation Laborer
11. Industry or business Still-Hildreth Sanatorium
FATHER
12. Name Unknown U
13. Birthplace ..... (City, town, or county) Mo. (State or foreign country)
MOTHER
14. Maiden name Celia
15. Birthplace ..... (City, town, or county) Mo. (State or foreign country) U
16. (a) Informant Mrs. Wm. Grant
(b) Address Macon, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/48 (Month) (Day) (Year)
(c) Place: burial or cremation Woodlawn, Macon, Mo.
18. (a) Signature of funeral director Albert Skinner
(b) Address Macon, Mo.
19. (a) 10-6-48 (Date received local registrar) (b) Ruth McNeely (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 21 year 1948 hour 7 minute 30 p.m.
21. I hereby certify that I attended the deceased from January, 1948, to Sept 21, 1948 that I last saw him alive on Sept 21, 1948 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Acute Myocarditis	2 days
Due to: Chronic Myocarditis	9 mon.
Due to: Arteriosclerosis and Pulmonary Infarction	? ?
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations: None	
Of autopsy	

PHYSICIAN
Underline the cause of 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? ..... (Specify type of place) 2
While at work? ..... (e) Means of injury .....
23. Signature R. D. Mason M.D. (M.D. or other)
Address Macon, Mo. Date signed 9/25/48

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 10
District File No. 10-48-1784
Date Filed OCT 14 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 ....., Registered Apprentice No....., working under my personal supervision.

Signed Albert S. Kennedy

Licensed Embalmer No. 75-1

P. O. Address Macon 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.