

UNITED STATES DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

40659
State File No. _____
Registrar's No. 148

FILED JAN 7 1949
Registration District No. 283

Primary Registration District No. 5655

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

1. PLACE OF DEATH:
(a) County Lawrence
(b) City or town Mt. Vernon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Missouri State Sanatorium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 79 days
In this community 79 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. Route #5 (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3: (a) PRINT FULL NAME Clyde A. Grace
(b) If veteran, name war No.
(c) Social Security No. 487-09-1390

4. Sex Male
5. Color or race white
6. (a) Single, widowed, married, divorced Married
(b) Name of husband or wife Unknown
(c) Age of husband or wife if alive Unknown years
7. Birth date of deceased April 17th 1902
(Month) (Day) (Year)

8. AGE: Years 46 Months 8 Days 12
If less than one day _____ hr. _____ min.

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

10. Usual occupation Butcher

11. Industry or business Armour & Company

12. Name Wm. James Grace

13. Birthplace Buchanan County Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Luella Cross

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

16. (a) Informant E McMichael, Record Clerk

(b) Address Mo. State San. Mt. Vernon, Mo.

17. (a) Removal (b) Date thereof 12-29-48
(Burial, cremation, or removal) (Monthly) (Day) (Year)

(c) Place: burial or cremation St. Joseph Mo

18. (a) Signature of funeral director Shawn Funeral Home
(b) Address St. Joseph Mo
(Specify type of place) (c) Means of injury _____

19. (a) 1-1-49 (b) Cecil Hendricks
(Date received local registrar) (Registrar's signature) 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 29
year 1948 hour 1:45 minute A. M.

21. I hereby certify that I attended the deceased from Oct. 11, 1948 to Dec. 29, 1948
that I last saw him alive on Dec. 29, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Post-pneumonectomy cardio-respiratory insufficiency
Due to Lung Abscess

Due to _____

Other conditions 114 P
(Include pregnancy, within 3 months of death)

Major findings: Pathologist's report
Of operations not been received.
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? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

23. Signature J. F. [unclear] (M. D. or other) MD
Address Mt. Vernon, Mo. Date signed 12-29-48

Duration Approx 1 Month
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

FEB 10 1949

RECEIVED

District Health Officer No. 6,

District File Number 149-3

Date Filed 1-5-49

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 Geo. B. Orr

Licensed Embalmer No. 946

P. O. Address Whittemore Dr

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.