

FILED FEB 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3798

BIRTH NO. _____ REG. DIST. NO. 354 PRIMARY REG. DIST. NO. 4519 Registrar's No. 47

1. PLACE OF DEATH a. COUNTY TEXAS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY TEXAS	
b. CITY OR TOWN Cabool		c. CITY OR TOWN Cabool	
d. FULL NAME OF HOSPITAL OR INSTITUTION /		d. STREET ADDRESS (If rural, give location) /	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) SARAH	b. (Middle) Tabitha	c. (Last) GRISHAM	JAN 28 1949		
5. SEX F	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Widowed	8. DATE OF BIRTH Feb 22 1898	9. AGE (In years last birthday) 90	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Elk Creek Mo.	

13a. FATHER'S NAME Wesley Hall		13b. MOTHER'S MAIDEN NAME Nancy Self		14. NAME OF HUSBAND OR WIFE Austin Grisham	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME R.B. Grisham ADDRESS Cabool Mo.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 24 hours	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Mania		II. OTHER SIGNIFICANT CONDITIONS Scitility			
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c)		992K	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan 27, 1949, to Jan 28, 1949, that I last saw the deceased alive on Jan 28, 1949, and that death occurred at 10:20 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Gurnett Long Price		23b. ADDRESS Cabool Mo		23c. DATE SIGNED Jan 29/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Jan 30-49		24c. NAME OF CEMETERY OR CREMATORY Hall Cemetery	
24d. LOCATION (City, town, or county) (State) Texas Mo.		DATE REC'D BY LOCAL REG. Feb 2-1949		REGISTRAR'S SIGNATURE Gaynell Cunningham	
25. FUNERAL DIRECTOR'S SIGNATURE Gaylor H. Elliott		ADDRESS Cabool Mo.			

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

RECEIVED 2-9-49
District Health Officer No. 8,
District File Number 249138
Date Filed 2-18-49

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.....

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed *Gaylord V. Elliott*

Licensed Embalmer No. *2252*

P. O. Address *Cabool 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.