

FILED JUL 30 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **22855**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **787**

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY OR TOWN <b>St. Joseph</b>		c. CITY OR TOWN <b>St. Joseph</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>44 years</b>		e. STREET ADDRESS (If rural, give location) <b>2216 Francis St.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>2216 Francis St.</b>			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)			
a. (First) <b>CHARLES</b>	b. (Middle) <b>E.</b>	c. (Last) <b>GRABLE</b>	<b>July 20, 1956</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Sept. 16, 1889</b>	9. AGE (In years last birthday) <b>66</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Credit manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Furniture Store.</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Dearborn, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>

13a. FATHER'S NAME <b>Joseph Grable</b>		13b. MOTHER'S MAIDEN NAME <b>Margaret Cox</b>		14. NAME OF HUSBAND OR WIFE <b>Lillian Grable</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>491-09-4423</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. C. E. Grable, 2216 Francis, St. Joseph,</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Occlusion</b>		DUPLICATE OF (b) <b>Coronary Occlusion</b>		<b>Instant</b>	
*This does not mean the mode of dying, such as heart failure, aethenia, etc. It means the disease, injury, or complication which caused death.		DUPLICATE OF (c) <b>myocardial insufficiency from previous coronary occlusion</b>		<b>1948</b>	
II. OTHER SIGNIFICANT CONDITIONS		<b>Lobar pneumonia June 1956</b>			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)		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 **June 1, 1956**, to **July 30, 1956**, that I last saw the deceased alive on **July 19, 1956**, and that death occurred at **12:15 p. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Deputy or title) <b>L. B. Senor</b>		23b. ADDRESS <b>St. Joseph Mo</b>		23c. DATE SIGNED <b>July 21, 1956</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		24b. DATE <b>7/24/1956</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	
				24d. LOCATION (City, town, or county) (State) <b>St. Joseph, Missouri</b>	

DATE REC'D BY LOCAL REG. <b>July 25, 1956</b>		REGISTRAR'S SIGNATURE <b>Kathleen M. Allison</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Beatrice Bowman St Joseph Mo</b>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 ..... Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *James B. Hawkins*

Licensed Embalmer No. *453*

P. O. Address *319 So 10th St*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.