

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3585

STATE FILE NUMBER

FILED MAR 4 1957

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 84

Health, Welfare, Public Service

300
1-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Adair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirksville</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kirksville</u> <u>0013</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>K.O. Hosp.</u>		Length of stay in lb <u>3 days</u>	d. STREET ADDRESS (If outside, give location) <u>208-E-McPherson</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>HATTIE</u> Middle <u>LEONA</u> Last <u>GRASSLE</u>			4. DATE OF DEATH <u>Feb. 24, 1957</u> Month <u>Feb.</u> Day <u>24</u> Year <u>1957</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 3, 1868</u>
9. AGE (In years last birthday) <u>88</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	11. BIRTHPLACE (City and state or country) <u>Noble Co. Indiana</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John C. Weaver</u>	
14. MOTHER'S MAIDEN NAME <u>Nancy Fretz</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-----</u> (If yrs, give war or dates of service) <u>-----</u>	
16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Dr. N. Sue Grassle, 208-E-McPherson</u> Address <u>Kirksville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mydriatic failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>cerebral thrombosis</u> DUE TO (c) <u>Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2-22-57</u> <u>2-24-57</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour <u>-----</u> Month, Day, Year <u>-----</u> a. m. <u>-----</u> p. m. <u>-----</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>1953</u> to <u>1957</u> and last saw her him alive on <u>2-24-57</u> Death occurred at <u>2:05 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>W. J. Johnson D.O.</u> (Degree or title) <u>2</u>		22b. ADDRESS <u>Kirksville, Mo.</u>	22c. DATE SIGNED <u>2-25-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2-26-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Highland Park Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Kirksville, Mo.</u>
24. FUNERAL DIRECTOR <u>Davis & Davis,</u> ADDRESS <u>Kirksville, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>3-1-1957</u>	26. REGISTRAR'S SIGNATURE <u>Doris W. Batliff</u>

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Robert B. Davis*.....

Licensed Embalmer No. 4219

P. O. Address Kirksville

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.