THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

5785

STATE FILE NUMBER

FILED FEB 25 1957

Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 26

1. PLACE OF DEATH a. COUNTY Pike	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Pike
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Louisiana, Mo. Inside Limits Yes ☒ No ☐	c. CITY OR TOWN Louisiana, Mo. 0821 Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 113 S. 16th Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 113 S. 16th Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print)	First: Elizabeth	Middle: L.	Last: Griever	4. DATE OF DEATH Month 2 / Day 15 / Year 57
5. SEX: Female	6. COLOR OR RACE: White /	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ 2 DIVORCED ☐	8. DATE OF BIRTH: 7/11/1883	9. AGE (In years last birthday): 74 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): Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country): Jamestown, Kentucky 1	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Benjamin F. Loy		14. MOTHER'S MAIDEN NAME: Amanda Griever		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: none	17. INFORMANT Address: Sidney McBeath, Louisiana, Mo		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral Vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 8 mths

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Arteriosclerotic Hypertensive Cardio-Vascular Disease. — 5 plus yrs.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): --- 443x

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 2

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 1952, to 2/15/57 and last saw her/him alive on 1/19/57

Death occurred at 8:45 A. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): [signature] M.D.	22b. ADDRESS: Louisiana, Mo.	22c. DATE SIGNED: 2/16/57	
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 2/17/57	23c. NAME OF CEMETERY OR CREMATORY: Louisiana Memorial Gardens	23d. LOCATION (City, town, or county) (State): Louisiana, Mo.
24. FUNERAL DIRECTOR: George O. Wagner	ADDRESS: Louisiana, Mo.	25. DATE RECD. BY LOCAL REG.: Feb 16, 1957	26. REGISTRAR'S SIGNATURE: Bernice Collier

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in Part I. Coroner cannot certify to a death due to natural causes. Diseases in Part I must be casually related.

27

300 -56

14-0

FEB 27 1957

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was en

by me, or by ....., Student Embalmer No.....

working under my personal supervision.

Student.....
Signature of Student Embalmer

Signed George O. Wagner

Licensed Embalmer No. 37

P. O. Address Louisiana

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.