

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

FILED APR 8 - 1957

State File No. **7465**

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. **5009** Registrar's No. **124**

1. PLACE OF DEATH a. COUNTY Adair 0010		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Adair	
b. CITY OR TOWN Wilson T.S.	c. LENGTH OF STAY (in this place) 8 months	c. CITY OR TOWN La Plata 0101	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION		e. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) Synthia Grant	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) March 27 1957
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5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 11-26-1869	9. AGE (In years last birthday) 87	IF UNDER 1 YEAR Month 4 Day 7	IF UNDER 24 HRS. Hours 7 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY at Home	11. BIRTHPLACE (City and State or Foreign Country) Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME James Behrmer	13b. MOTHER'S MAIDEN NAME Mary Atter	14. NAME OF HUSBAND OR WIFE W.B. Grant
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (m. no. or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME C.T. Davison	ADDRESS Gibbs, Mo
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3 days 10 yrs.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral thrombosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio Sclerosis DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) 332x
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	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 15, 1956, to Mar 27, 1957, that I last saw the deceased alive on Mar 27, 1957, and that death occurred at 10 a. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Harold D. Lehn M.D.	23b. ADDRESS La Plata, Mo	23c. DATE SIGNED 3/27/57
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3-29-57	24c. NAME OF CEMETERY OR CREMATORY Sturkey	24d. LOCATION (City, town, or county) (State) Adair Co., Mo.
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DATE REC'D BY LOCAL REG. 3-30-1957	REGISTRAR'S SIGNATURE Doris W. Rathoff	FUNERAL DIRECTOR'S SIGNATURE D.S. Christ	ADDRESS La Plata, Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

350

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 *D. S. Christie*.....

Licensed Embalmer No. *1109*.....

P. O. Address *Fall River*.....

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.