

FILED APR 26 1957

STANDARD CERTIFICATE OF DEATH

14746
STATE FILE NUMBER
3663

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in lb		STREET ADDRESS (If outside, give location)	
3. NAME OF DECEASED (Type or print)		First WILLIAM Middle Last GRUBE		4. DATE OF DEATH Month Day Year	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE in years (Month/Day)		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give unit or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO (b)		DUE TO (c)	
CONDITIONS, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT <input checked="" 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.)		E903.5	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20e. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from _____, to _____, and last saw her alive on _____ Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.		22. SIGNATURE (Type or print) Deputy		22b. ADDRESS	
23a. BURIAL, CREMATION, REBURYAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
23d. LOCATION (City, town, or county) (State)		24. FUNERAL DIRECTOR ADDRESS		25. DATE RECD. BY LOCAL REG.	
26. REGISTRAR'S SIGNATURE		27. REGISTRAR'S SIGNATURE		28. REGISTRAR'S SIGNATURE	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Health, & Welfare Public Services
6650
300
1-56
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
Securing the Medical Certificate in time is essential.

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.....

Licensed Embalmer No.....

P. O. Address.....

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.