

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

2058

STATE FILE NUMBER

FILED FEB 5 1958

Registration District No. 217 Primary Registration District No. 3045 Registrar's No. 5

|   |                              |  |                                     |  |  |  |  |
|---|------------------------------|--|-------------------------------------|--|--|--|--|
| 1. PLACE OF DEATH   |                              |  |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)    |  |  |  |
| a. COUNTY <u>Mississippi</u>  |                              | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Charleston</u>  |                                     | a. STATE <u>Missouri</u>   |  | b. COUNTY <u>Miss.</u>   |  |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>415 W. Market</u>                                  |                              | Length of stay in 1b <u>60 yrs.</u>  |                                     | c. CITY OR TOWN <u>Charleston</u>  |  | d. STREET ADDRESS <u>415 W. Market St.</u>   |  |
| 3. NAME OF DECEASED (Type or print)   |                              |  |                                     | 4. DATE OF DEATH   |  |  |  |
| First <u>Bert (Burt)</u>  |                              | Middle <u>(Gregory)</u>  |                                     | Last <u>Grigsby</u>  |  | Month <u>Jan.</u> Day <u>24,</u> Year <u>1958</u>  |  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>Col.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 2, 1887</u> | 9. AGE (In years last birthday) <u>70</u>  |  | IF UNDER 1 YEAR IF UNDER 24 HRS.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>                           |                              | 100. KIND OF BUSINESS OR INDUSTRY <u>---</u>   |                                     | 11. BIRTHPLACE (City and state or country) <u>Mayfield, Ky.</u>                          |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |
| 13. FATHER'S NAME <u>Green Grigsby</u>  |                              |  |                                     | 14. MOTHER'S MAIDEN NAME <u>Unk.</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |                              | 16. SOCIAL SECURITY NO. <u>490-28-7016</u>   |                                     | 17. INFORMANT <u>Mrs. Essie Grigsby, 415 W. Market, Charleston, Mo.</u>                  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]   |                              |  |                                     |  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART I. DEATH WAS CAUSED BY:  |                              |  |                                     |  |  |  |  |
| IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u>   |                              |  |                                     |  |  | <u>55 days</u>   |  |
| DUE TO (b) <u>Hypertensive Cardia-Vascular Dis</u>  |                              |  |                                     |  |  | <u>unkn</u>  |  |
| DUE TO (c) _____  |                              |  |                                     |  |  |  |  |
| 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"/> <u>2</u>                             |  |
| 20a. ACCIDENT <input type="checkbox"/>  |                              | SUICIDE <input type="checkbox"/>   |                                     | HOMICIDE <input type="checkbox"/>  |  | 200. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>443X</u> |  |
| 20c. TIME OF INJURY   |                              | Hour <u>---</u> Month <u>---</u> Day <u>---</u> Year <u>---</u>  |                                     | 20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 20f. CITY, TOWN, OR LOCATION   |  |
| 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>4 Dec 57</u> to <u>24 JAN 58</u> and last saw her/him alive on <u>24 JAN 58</u>               |                              |  |                                     |  |  |  |  |
| Death occurred at <u>2:30 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.             |                              |  |                                     |  |  |  |  |
| 22a. SIGNATURE (Degree or title) <u>John L Sample M.D.</u>  |                              |  |                                     | 22b. ADDRESS <u>Charleston Mo</u>  |  | 22c. DATE SIGNED <u>28 Jan 58</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                              | 23b. DATE <u>Jan. 28, 1958</u>   |                                     | 23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>                             |  | 23d. LOCATION (City, town, or county) (State) <u>Charleston, Missouri</u>                                |  |
| 24. FUNERAL DIRECTOR <u>L. R. Sparks</u>  |                              |  |                                     | ADDRESS <u>Charleston, Mo.</u>   |  | 25. DATE RECD. BY LOCAL REG. <u>1-31-58</u>  |  |
|   |                              |  |                                     | 26. REGISTRAR'S SIGNATURE <u>Worachy B. Haddock</u>                                      |  |  |  |

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

Miss. Co. Health D

County File No. \_\_\_\_\_

Date Filed 2-4-5

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 Edward A. Purkin

Licensed Embalmer No. .... 50  
2501 Po  
Cairo

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.