

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-001681

STATE FILE NUMBER

FILED JAN 30 1959

Registration District No. 150

Primary Registration District No. 4241

Registrar's No. 22

300  
-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Oak Grove</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Oak Grove</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>city</b>		Length of stay in 1b <b>45 years</b>	d. STREET ADDRESS (If outside, give location) <b>city</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>GRACE</b> Middle <b>JEWELL</b> Last <b>SAYLOR</b>			4. DATE OF DEATH Month <b>Jan</b> Day <b>18</b> Year <b>1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 5 1912</b>	9. AGE (In years last birthday) <b>46</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>clerk-Supt.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Int. Revenue Dept.</b>	11. BIRTHPLACE (City and state or country) <b>Independence, Mo</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13a. FATHER'S NAME <b>Louis Pemberton</b>		13b. MOTHER'S MAIDEN NAME <b>Bessie Bynum</b>		14. NAME OF HUSBAND OR WIFE <b>Gordon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>493-32-2819</b>		17. INFORMANT <b>Gordon Saylor Oak Grove, Mo</b> 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) <b>Carcinoma of Ovary with metastasis to Spleen and lung.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b>
Conditions, if any, which gave rise to above cause (a), starting 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 (a) <b>1750</b>					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 _____ a.m. _____ p.m.			20d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, store, street, office bldg., etc.) _____		20f. CITY, TOWN, OR LOCATION _____		COUNTY _____	STATE _____
21. I attended the deceased from <b>May 1958</b> to <b>1-18-59</b> and last saw him alive on <b>1-18-59</b> Death occurred at <b>10:20 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>James W. Dorian MD</b> (Degree or title)			22b. ADDRESS <b>Oak Grove, Mo</b>		22c. DATE SIGNED <b>1-20-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1/21/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b>		23d. LOCATION (City, town, or country) (State) <b>Oak Grove Mo.</b>	
24. FUNERAL DIRECTOR <b>Webb Funeral Home Oak Grove Mo</b>		25. DATE RECD. BY LOCAL REG. <b>1-23-59</b>		26. REGISTRAR'S SIGNATURE <b>W. B. Langford</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

JAN 30 1959

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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 William Free

Licensed Embalmer No. 4723

P. O. Address Blue Springs

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.