

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012594

STATE FILE NUMBER

APR 28 1959 Registration District No. 53 Primary Registration District No. 3009 Registrar's No. 143

300
1-57

1. PLACE OF DEATH a. COUNTY - Cape Girardeau Chargant - San Grant		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only). OR TOWN Jackson Mo.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Troy Mo. 0570 Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION R.F.D. 1		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED First Middle Last (Type or print) Margaret Ann Grant			4. DATE OF DEATH Month Day Year April 19 1959
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 16 1864
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Keeping House	9. AGE (In years (at birthday)) 94
11. BIRTHPLACE (City and state or country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Henry Baley Hamilton		13b. MOTHER'S MAIDEN NAME Barbara Ann Hamesley	14. NAME OF HUSBAND OR WIFE John W. Grant
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Roger Brown Jackson Mo,
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Myocardial failure</u> DUE TO (c) <u>Shagial Cholera</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>6 hours</u> <u>3 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Fracture of rt hip, senility</u>			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 Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <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 016 COUNTY STATE
21. I attended the deceased from <u>3-5-59</u> to <u>4-19-59</u> and last saw her alive on <u>4-19-59</u> Death occurred at <u>2:10 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Walter W. Butler D.O.</u> (Degree or title)		22b. ADDRESS <u>107 E Washington Jackson Mo</u>	22c. DATE SIGNED <u>4-20-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4-21-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>River View</u>	23d. LOCATION (City, town, or county) (State) <u>Louisiana Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Deneke-Laird Jackson</u>		25. DATE RECD. BY LOCAL REG. <u>4-21-59</u>	26. REGISTRAR'S SIGNATURE <u>Irene Kasten</u>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 *R. O. Laine*

Licensed Embalmer No. *45-38*

P. O. Address *Jackson, Mo*

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.