

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018763
STATE FILE NUMBER

FILED JUN 4 1959 Registration District No. 294 Primary Registration District No. 3056 Registrar's No. 114

300
-57

1. PLACE OF DEATH a. COUNTY Randolph		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Randolph	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Moberly		c. CITY OR TOWN Moberly	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 321 S. 4th St.		Length of stay in lb 14 yrs.	
3. NAME OF DECEASED (Type or print) Louise Grant		4. DATE OF DEATH Month 5 Day 24 Year 59	
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 4/13/1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 81
11. BIRTHPLACE (City and state or country) Bado, Mo		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Abraham Burriss		13b. MOTHER'S MAIDEN NAME Malinda Denton	14. NAME OF HUSBAND OR WIFE George (dec)
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 Mrs Bessie Harlin
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Arteriosclerosis DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 20 hrs.
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 WORK <input type="checkbox"/> 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 1954 to May 24, 1959 and last saw her alive on May 24, 1959 Death occurred at 1100 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Robert Hesson, M.D.		22b. ADDRESS 121 S. Wms. Moberly, Mo	22c. DATE SIGNED 5/26/59
23a. BURIAL, CREMATION, REMOVAL (Specify) B	23b. DATE 5/27/59	23c. NAME OF CEMETERY OR CREMATORY Roselawn	23d. LOCATION (City, town, or county) (State) Marceline, Mo
24. FUNERAL DIRECTOR James McLaughlin		25. DATE RECD. BY LOCAL REG. 5-27-59	26. REGISTRAR'S SIGNATURE Leah Blouie

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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 *Jamer B. McClelland*

Licensed Embalmer No. *4230*
P. O. Address *Brookfield, 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.