

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-022037

STATE FILE NUMBER

Registration District No. 171 Primary Registration District No. 5638 Registrar's No. 1

**1. PLACE OF DEATH**  
a. COUNTY Lafayette  
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Spencer Inside Limits Yes  No   
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION City Length of stay in 1b 10 mo

**2. USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)  
a. STATE Mo b. COUNTY Lafayette  
c. CITY OR TOWN Bates City Inside Limits Yes  No   
d. STREET ADDRESS City (If outside, give location) Reside on Farm Yes  No

**3. NAME OF DECEASED** (Type or print) First Middle Last Theodore J Grasshider  
4. DATE OF DEATH Month Day Year 5-30-59

**5. SEX** M **6. COLOR OR RACE** Wh **7. MARRIED**  **NEVER MARRIED**   
**WIDOWED**  **DIVORCED**   
**8. DATE OF BIRTH** Jan-13-06 **9. AGE** (In years last birthday) 53 **FUNDER 1 YEAR** Months Days **IF UNDER 24 HRS.** Hours Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, or retired) State City Ord. Guard **10b. KIND OF BUSINESS OR INDUSTRY** Lee Summit Mo USA **11. BIRTHPLACE** (City and state or country) Lee Summit Mo USA **12. CITIZEN OF WHAT COUNTRY?** USA

**13. FATHER'S NAME** Joseph Grasshider **13b. MOTHER'S MAIDEN NAME** Bertha Nolte Imogene **14. NAME OF HUSBAND OR WIFE** Imogene

**15. WAS DECEASED EVER IN U. S. ARMED FORCES?** (Yes, no, or unknown) (If yes, give war or dates of service) Yes **16. SOCIAL SECURITY NO.** 486-26-2086 **17. INFORMANT** Imogene Grasshider Address Bates City 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) Crowley Fluorosis  
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 (a) — **19. WAS AUTOPSY PERFORMED?** YES  NO  2

**20a. ACCIDENT**  **SUICIDE**  **HOMICIDE**  **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. Month, Day, Year —

**20d. INJURY OCCURRED WHILE AT WORK**  **NOT WHILE AT WORK**  **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** Oct 1958, to May 30-1959 and last saw <sup>her</sup> alive on May 20-1959  
Death occurred at 9:12 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

**22a. SIGNATURE** (Degree or title) John W. Williams MD **22b. ADDRESS** Oak Grove Mo **22c. DATE SIGNED** 6/1/59

**23a. BURIAL, CREMATION, REMOVAL** (Specify) Burial **23b. DATE** 6-2-59 **23c. NAME OF CEMETERY OR CREMATORY** Blue Springs Mo **23d. LOCATION** (City, town, or county) (State) Blue Springs Mo

**24. FUNERAL DIRECTOR** Webb Funeral Home **ADDRESS** Oak Grove Mo **25. DATE RECD. BY LOCAL REG.** 6-1-1959 **26. REGISTRAR'S SIGNATURE** Emma Davidson

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

