

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-039006**

FILED VS DEC 7 1959

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STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Gentry</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		c. CITY OR TOWN <u>King City</u>	
Length of stay in 1b <u>2 Mo. 8 da</u>		Inside Limits <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hosp. #2</u>		d. STREET ADDRESS (If outside, give location) <u>W. Vermont St.</u>	
Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>Marie</u> Last <u>Grace</u>			4. DATE OF DEATH Month <u>November</u> Day <u>22</u> Year <u>1959</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8/22/97</u>
9. AGE (last birthday) <u>62</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>22</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HR Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	11. BIRTHPLACE (City and state or country) <u>Gentry Co. Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Theodore Baker</u>	
13b. MOTHER'S MAIDEN NAME <u>Ma y Thompson</u>		14. NAME OF HUSBAND OR WIFE <u>Ray Grace (Dec.)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>495 07 0655</u>	
17. INFORMANT <u>Records State Hosp. #2</u>		Address <u>St. Joseph Mo.</u>	
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>Cerebra Thrombosis</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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. Month, Day, Year _____		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>Nov. 22, 1959</u> to <u>Nov. 22, 1959</u> and last saw her <u>her</u> alive on <u>Nov. 22, 1959</u> Death occurred at <u>4:45 AM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>R.P. Price M.D.</u>		22b. ADDRESS <u>St. Hosp. #2 St. Joseph, Mo</u>	22c. DATE SIGNED <u>11/22/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Nov. 22, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Grandview Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Albany, Mo.</u>
24. FUNERAL DIRECTOR <u>Harold E. Hooded</u>		25. DATE RECD. BY LOCAL REG. <u>Nov. 30, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Goodell</u>

DOCUMENT

R.P. Price, M.D. MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed Harold E. Keadrel

Licensed Embalmer No. 4609

P. O. Address King City

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.