

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

FILED VS JAN - 8 1960 / 57

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STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY Jasper				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Jasper							
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Carthage		Length of stay in 1b 1 day		c. CITY OR TOWN Diamond		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION McCune-Brooks hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Route 1		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last ALBERT HARRISON GRENINGER				4. DATE OF DEATH Month Day Year Dec 31, 1959							
5. SEX male		6. COLOR OR RACE white		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 9-10-83		9. AGE (last birthday) 76		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired farmer			10b. KIND OF BUSINESS OR INDUSTRY farming		11. BIRTHPLACE (City and state or country) Jasper County, Mo		12. CITIZEN OF WHAT COUNTRY USA				
13a. FATHER'S NAME Aquila Greninger			13b. MOTHER'S MAIDEN NAME Martha Moss			14. NAME OF HUSBAND OR WIFE Greninger Luzenia Guthrie					
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. 300-09-2220		17. INFORMANT Address Mrs. A.H. Greninger, Rt 1, Diamond, 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) <i>Cerebral Hemorrhage</i>								INTERVAL BETWEEN ONSET AND DEATH <i>5 hrs.</i>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>Hypertension &amp; Arteriosclerosis</i>								DUE TO (c) <i>Unknown</i>			
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 <i>12-31-59</i> to <i>12-31-59</i> and last saw her/him alive on <i>12-31-59</i> . Death occurred at <i>5:10 p</i> m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <i>[Signature]</i> (Degree or title) MD						22b. ADDRESS Carthage, Mo			22c. DATE SIGNED 1-2-60		
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE Jan 5, 1960		23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery			23d. LOCATION (City, town, or county) Carthage, Mo			(State)	
24. FUNERAL DIRECTOR ADDRESS Knell Mortuary, Carthage, Mo				25. DATE RECD. BY LOCAL REG. 1-2-60		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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 me

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Frank W. Kuehl*

Licensed Embalmer No. 4440

P. O. Address Carthage, 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.