

## I DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-014549

FILED VS. MAY 5 1960 71

Primary Registration District No. 3012

Registrar's No. 48

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Clay</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Clay</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Excelsior Springs</b>		Length of stay in 1b <b>Lifetime</b>		c. CITY OR TOWN <b>Excelsior Springs</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Excelsior Springs Hospital</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>534 Elms Blvd.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sallie</b> Middle <b>Ann</b> Last <b>Grimes</b>				4. DATE OF DEATH Month <b>Apr.</b> Day <b>19,</b> Year <b>1960</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>9-25-1875</b>	9. AGE (last birthday) <b>84</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (City and state or country) <b>Clay County, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13a. FATHER'S NAME <b>Thomas Grimes</b>			13b. MOTHER'S MAIDEN NAME <b>Martha Barryman</b>			14. NAME OF HUSBAND OR WIFE <b>None</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Charles Scott, 534 Elms Blvd. Excelsior Springs, Mo.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CA of gall bladder</b>							INTERVAL BETWEEN ONSET AND DEATH <b>sev. yrs.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							DUE TO (b) _____	
DUE TO (c) _____							DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arthritis severe,</b>					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 <b>April 9, 1960</b> to <b>April 19, 1960</b> and last saw her <b>April 19, 1960</b> Death occurred at <b>2:30 pm.</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Decedent or title) <i>M. D. Excelsior Springs, Missouri</i>				22b. ADDRESS <b>M. D. Excelsior Springs, Missouri</b>		22c. DATE SIGNED <b>4/29/60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>4-21-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Plattsburg</b>		23d. LOCATION (City, town, or county) <b>Plattsburg, Mo.</b>		(State)		
24. FUNERAL DIRECTOR <b>Prichard Funeral Home, Inc.</b> ADDRESS <b>Excelsior Springs, Missouri</b>			25. DATE RECD. BY LOCAL REG. <b>4-29-60</b>		26. REGISTRAR'S SIGNATURE <i>Barolene Hutchings</i>			

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

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

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed Ludie Jarman

Licensed Embalmer No. 4589

P. O. Address Excelsior Springs

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.