

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

JAN 25 1940

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

25547  
Do not use this space.

1. PLACE OF DEATH

(a) County Laclede 2 Registration District No. 451  
 (b) Township Eldridge 0 Primary Registration District No. 5616 Registered No. \_\_\_\_\_  
 (c) City Eldridge (d) Street No. \_\_\_\_\_ (If death occurred in Hospital or Institution, write its name instead of street and number) St. \_\_\_\_\_  
 (e) Length of residence in city or town where death occurred yrs. mos. 10 ds. (f) How long in U. S., if of foreign birth? yrs. mos. da. \_\_\_\_\_

2. PRINT FULL NAME

652 Wilma Grimes  
 (a) Residence, No. Laclede Co. Eldridge, Mo. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>single</u>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF			
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>7-8-1940</u>			
7. AGE YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
		<u>10</u>	
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>at home</u>		
	9. Industry or business in which work was done, as saw mill, bank, etc.		
	10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Eldridge, Missouri</u>			
FATHER	13. NAME <u>Joel Grimes</u>		
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Missouri</u>		
MOTHER	15. MAIDEN NAME <u>Heldie Jennings</u>		
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Missouri</u>		
17. INFORMANT (ADDRESS) <u>Eldridge, Missouri</u>			
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Montarb</u> DATE _____ 19__			
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>406</u>			
20. FILED <u>Aug 2 1940</u> <u>Nara Cole</u> Local Registrar.			

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-18, 1940

22. I HEREBY CERTIFY, That I attended deceased from 7-18, 1940, to 7-18, 1940  
 I last saw him alive on 7-18, 1940. Death is said to have occurred on the date stated above, at 9 P. m.  
 The principal cause of death and related causes of importance were as follows:  
Coronary arteriosclerosis  
 Date of onset \_\_\_\_\_

Other contributory causes of importance: JAD

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no  
 If so, specify \_\_\_\_\_  
 (Signed) Joel Grimes Father, M. D.  
Eldridge, Mo. (Address)

RECEIVED  
District Health Officer No. 7.  
District File Number 8-40-1087  
Date Filed 8-7-40

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**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 .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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 this body is not embalmed, above space should be left blank.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 25-5-47

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 457

Primary Registration District No. 5716

Registrar's No. \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Laclede  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME Wilma Grimes

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced 8

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased: \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years \_\_\_\_\_ Months 10 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace: \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) Nora Cole (Registrar's signature)

(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: month 7 day 18 year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Joel Grimes (M. D. or other) \_\_\_\_\_

Address Eldridge \_\_\_\_\_ Date signed Sept 11 40

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

