

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 10-77 Primary Registration District No. LAXI Registrar's No.

1. PLACE OF DEATH:
(a) County Shannon
(b) City or town Rural Jasper 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 3 months _____ (Specify whether)
years, months or days _____

3. (a) PRINT FULL NAME John Franklin Grizzle
3. (c) Social Security No. 491-05-0295
8. (b) If veteran, name war no.

4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced m.
6. (b) Name of husband or wife Lulalia Grizzle 6. (c) Age of husband or wife if alive 20 years
7. Birth date of deceased 3 22-1910
(Month) (Day) (Year)

8. AGE: Years 30 Months 3 Days 11 If less than one day _____ hr. _____ min.

9. Birthplace Lawton Okla.
(City, town, or county) (State or foreign country)

10. Usual occupation Iron Worker

11. Industry or business _____
MOTHER FATHER { 12. Name Thomas F. Grizzle
13. Birthplace Georgia
(City, town, or county) (State or foreign country)
14. Maiden name Maud Byrd
15. Birthplace Georgia
(City, town, or county) (State or foreign country)

16. (a) Informant Alia Grizzle
(b) Address Round Springs
17. (a) Burial (b) Date thereof 7-5-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Springfield Mo.

18. (a) Signature of funeral director Robert Matthews
(b) Address Salem Mo.
19. (a) 7-4-40 (b) Frank Hyde MD
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Shannon
(c) City or town Rural Jasper Township
(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 July day 3
year 1940 hour 110 minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
that I last saw him alive on July - 3 - _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Hodgkins Disease

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

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 Frank Hyde (M. D. or other) _____
Address Business Mo. Date signed 7-4-40

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

NOV 15 1946

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.....

W. D. Holron

....., Registered Apprentice No.....

working under my personal supervision.

RECEIVED

District Health Officer No. 5,

District File Number 240.808

Date Filed 7-22-48

Signed

W. D. Holron

Licensed Embalmer No. 928

P. O. Address

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