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-39
X23159

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
6005 Park Avenue
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **30 Years**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Caroline Grimmert**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife **--** 6. (c) Age of husband or wife if alive **--** years

7. Birth date of deceased **May 27 1866**
(Month) (Day) (Year)

8. AGE: Years **74** Months **3** Days **4** If less than one day hr. min.

9. Birthplace **Macoupin County Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **Operator**

11. Industry or business **Western Union Telegraph Co.**

12. Name **John C. Grimmert**

13. Birthplace **Philadelphia Tennessee**
(City, town, or county) (State or foreign country)

14. Maiden name **Elizabeth Lair**

15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Miss J. M. Steeber**
(b) Address **3925 Oak Ave**

17. (a) **Funeral** (b) Date thereof **Sept. 4, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **High Mt. Union Cemetery**

18. (a) Signature of funeral director **J. N. Newcomb Sons**
(b) Address **1401 Brush Creek Blvd**

19. (a) **Sept. 4, 1940** (b) **M. M. Cron**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **6005 Park Avenue**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? **--** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **September** Day **1st**
year **1940** hour **1** minute **40 P.M.**

21. I hereby certify that I attended the deceased from **Sept 19 1940** to **Sept 19 1940**, 19...; that I last saw him **alive** on **Sept 19 1940**, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Coronary Thrombosis**
Due to **Acute Coronary Thrombosis**

Due to **Pulmonary Embolism**
Other conditions **Pulmonary Embolism**
(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 **Sept 4 1940**
(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? **---**

(Specify type of place) **---** (e) Means of injury **---**
23. Signature **Russell Jones** (M. D. or other)
Address **---** Date signed **---**

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

MOTHER FATHER

8212

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 George M. Collier

Licensed Embalmer No. 3839

P. O. Address D.C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. 3469

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
6005 Park Ave
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community 30 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Caroline Grummett

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

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

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 Days If less than one day
hr. 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) Nov 18 / 1940 (Date received local registrar) (b) Margaret M. Brown (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits write "RURAL")
(d) Street No. 6005 Park Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH. Month day 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: Acute Cardiac edema Pulmonary Emphysema

Due to.
Due to. From alcohol poisoning (Toxic ingestion) 163

Other conditions. (Include pregnancy within 3 months of death)

Major findings: Of operations. Of autopsy.

Duration
PHYSICIAN
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) suicide?

(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 OTBth (M. D. or other)

Address. Date signed.

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

SUPPLEMENTAL COPY

5.309.076