

No. 2
-1-4-41
5-17-39
I X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 5970
Registrar's No. 742

RECD MAR 14 1941
Registration District No. 299

Primary Registration District No. 100

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

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: Kansas City General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution two days
(Specify whether years, months or days) 16 yrs

3. (a) PRINT FULL NAME WILLIAM F. Grigsby
3. (b) If veteran, name war
3. (c) Social Security No. Unknown

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mrs. Cora Grigsby 6. (c) Age of husband or wife if alive 50 years
7. Birth date of deceased May 7 1886
(Month) (Day) (Year)

8. AGE: Years 54 Months 9 Days 12 If less than one day hr. min.

9. Birthplace Pettigrew Ark
(City, town, or county) (State or foreign country)

10. Usual occupation Stone Mason

11. Industry or business

MOTHER FATHER { 12. Name no record
13. Birthplace no record 9
(City, town, or county) (State or foreign country)
14. Maiden name no record
15. Birthplace no record 9
(City, town, or county) (State or foreign country)

16. (a) Informant Ralph Grigsby

(b) Address 2747 1/2 Indiana

17. (a) Burial (b) Date thereof 2-21-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Bentley

(b) Address 5811 Troost

19. (a) 2/20/1941 (b) M. M. Corone
(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. 2747 1/2 Indiana
(If rural, give location)
(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 19th year 1941 hour 10:00 P.M. minute M.

21. I hereby certify that I attended the deceased from 1-17-41 19... to 2-19-41 19...
that I last saw him alive on 2-19-41 19...
and that death occurred on the date and hour stated above.

Immediate cause of death Peritonitis and ruptured gangrenous appendicitis

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 Dr. R. Shaw (M. D. or other)
Address Med. Dir. K.C. Gen. Hospital Date signed

Duration
Physician
Underline the cause to which death should be charged statistically.

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 Guy Buffington

Licensed Embalmer No. 2756

P. O. Address K. C. 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; fact should be so stated above.