

Registration District No. 289

Primary Registration District No. 5407

Registrar's No. 17

3.5  
0  
0  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD.

1. PLACE OF DEATH: **COTTON H. TWP.**

(a) County **DUNKLIN**

(b) City or town **WILSON CITY**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **OFFICE OF DR. MITCHELL**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **2 Hr.**  
(Specify whether)

In this community **Life**  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Dunklin**

(c) City or town **Berne Rural 35**  
(If outside city or town limits, write "RURAL")

(d) Street No. **0**  
(If rural, give location)

(e) Citizen of foreign country? **0** (Yes or No)  
If yes, name country **0**

3. (a) PRINT FULL NAME **NO NAME "GRINDSTAFF"**

3. (b) If veteran, name war **—**

3. (c) Social Security No. **—**

4. Sex **MALE**

5. Color or Race **WHITE**

6. (a) Single, widowed, married, divorced **0**

6. (b) Name of husband or wife **—**

6. (c) Age of husband or wife if alive **—** years

7. Birth date of deceased **MAY 10 - 42**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

**4** hr. min.

9. Birthplace **NEAR CAMPBELL MO**  
(City, town, or county) (State or foreign country)

10. Usual occupation **BABY**

11. Industry or business **—**

MOTHER FATHER

12. Name **Clinton Grindstaff**

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

14. Maiden name **Bethna Saines**

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

16. (a) Informant **Clinton Grindstaff**

(b) Address **Berne Mo**

17. (a) **Burial** (b) Date thereof **5-15-42**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Bethna Friends**

18. (a) Signature of funeral director **Berne Rural**

(b) Address **—**

19. (a) **1288** (b) **D. D. Elder**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **5/14/1942** day **14** year **1942** hour **8** minute **30** P.M.

21. I hereby certify that I attended the deceased from **5/10/42** to **5/14/42**, 19 **19**  
that I last saw him alive on **5/14/42**, 19 **19**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Septicemia**  
**Obstruction** **4 days**

Due to **Congenital defects**

Due to **—**

Other conditions **—**  
(Include pregnancy within 3 months of death) **157g**

Major findings: **—**

Of operations **—**

Of autopsy **none**

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) **—**

(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? **—**

23. Signature **S. E. Mitchell** (M. D. or other) **Mo. D.**  
Address **Malden Mo** Date signed **5/14/42**

RECEIVED

District Health Office No. 2,

District File Number 642-792

Date Filed JUN 23 1942

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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, fact should be so stated above.**