S. No. 2
I—9-4-41
S-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

1991

State File No. .....

FILED FEB 3 1943

Registration District No. 73 Primary Registration District No. 4138 Registrar's No. 3

1. PLACE OF DEATH:
(a) County: CLINTON
(b) City or town: LATHROP
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:
(a) State: MISSOURI (b) County: CLINTON 25
(c) City or town: LATHROP 20
(If outside city or town limits, write "RURAL")
(d) Street No. 1
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: Essie Joe Grayson
3. (b) If veteran, name war: —
3. (c) Social Security No. —
4. Sex: Female 3
5. Color or race: Colored
6. (a) Single, widowed, married, divorced: Od.
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased: June (Month) 21 (Day) 1942 (Year)

8. AGE: Years 0 Months 5 Days 4 If less than one day ..... hr. ..... min.

9. Birthplace: Plattsburg (City, town, or county) - Mo. 0 (State or foreign country)
10. Usual occupation .....
11. Industry or business .....

MOTHER FATHER
12. Name: Harry R. Grayson
13. Birthplace: Illinois (City, town, or county) MO 0 (State or foreign country)
14. Maiden name: Mamie M. Watts
15. Birthplace: Lathrop (City, town, or county) MO 0 (State or foreign country)

16. (a) Informant: Harry R. Grayson
(b) Address: Lathrop. Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1-26-43 (Month) (Day) (Year)
(c) Place: burial or cremation: Lathrop - Mo -
18. (a) Signature of funeral director: DeMoss Crunk
(b) Address: Lathrop Mo
19. (a) 1-26-43 (Date received local registrar) (b) Mrs. Kathleen Harris (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 25 year 1943 hour 1 minute 9 M.
21. I hereby certify that I attended the deceased from Jan. 23 1943 to Jan. 25 1943 and that I last saw him alive on Jan. 24 1943 and that death occurred on the date and hour stated above.

Immediate cause of death: Bronchial Pneumonia — Duration

Due to .....

Due to .....

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

Major findings:
Of operations .....
Of autopsy .....

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? (Specify type of place)
While at work: (e) Means of injury: 0
23. Signature: F. J. Longwell (M. D. or other)
Address: Lathrop, Mo. Date signed 1/25/43

1086 (Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was ~~embalmed~~ NOX by me, or by.....

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

working under my personal supervision.

Signed.....

Licensed Embalmer No. 2533

P. O. Address Lathrop, 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.

S. No. 2B
M—8-21-41
I X29258

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 1991

Registration District No. 25 | Primary Registration District No. 4138 | Registrar's No. 9

1. PLACE OF DEATH:
(a) County: Clinton
(b) City or town: Lathrop (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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME: Essie Jae Sharpson
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex: F
5. Color or race: B
6. (a) Single, widowed, married, divorced: S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive
7. Birth date of deceased: June 21 1943 (Month) (Day) (Year)
8. AGE: Years | Months: 5 | Days | If less than one day: hr. min.
9. Birthplace: (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day
year 1943 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw h alive on 19; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Bronchial Pneumonia	1
Due to: Chronic Nephritis	
Due to:	
Other conditions (Include pregnancy within 3 months of death): 131 b	

Major findings:
Of operations
Of autopsy

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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work (e) Means of injury
23. Signature H. Longfield (M. D. or other)
Address Lathrop, Mo. Date signed

SUPPLEMENTARY