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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

37286

State File No.

4709

FILED NOV 19 1943

Registration District No. 1

Primary Registration District No. 1002

Registrar's No.

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:  
K. C. General Hospital No. 10  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 hrs. 55 min  
(Specify whether  
In this community 1 month  
years, months or days) Marie

3. (a) PRINT FULL NAME Hattie Grissinger

3. (b) If veteran, name war no 3. (c) Social Security No. none

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

6. (b) Name of husband or wife Carley 6. (c) Age of husband or wife if alive emp years

7. Birth date of deceased Sept 27 1895  
(Month) (Day) (Year)

8. AGE: Years 48 Months 1 Days 8 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business same

12. Name Fred Eden

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

14. Maiden name Jean Smith

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

16. (a) Informant Dakely Grissinger

(b) Address 2723 Holmes

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/8/43 (Month) (Day) (Year)

(c) Place: burial or cremation Burlington Junction, Mo

18. (a) Signature of funeral director Stanberry

(b) Address Standberry Mo

19. (a) 11-6-43 (Date received local registrar) (b) D. E. 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. 2723 Holmes  
(If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 5th  
year 1943 hour 11 minute 35 P. M.

21. I hereby certify that I attended the deceased from November 5th 1943 to November 5th 1943  
that I last saw her alive on November 5th 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral vascular accident Duration \_\_\_\_\_

Due to 830'

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy See above

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? \_\_\_\_\_

While at work \_\_\_\_\_ (Specify type of place) Means of injury \_\_\_\_\_

23. Signature Arney K. Thom (M, D, or other) Med. Dir. Gen'l Hosp.

Address 11-6-43 Date signed \_\_\_\_\_

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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..... *Ray E Snow* .....

Licensed Embalmer No. *2570* .....

P. O. Address..... *R @ MW* .....

**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.**