

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12-12-43

Registration District No. 123

Primary Registration District No. 5458

Registrar's No. 12-

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Walnut Grove R2
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Rural Walnut Grove Township
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution nil
(Specify whether)

In this community 50 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39

(c) City or town Walnut Grove R2
(If outside city or town limits, write "RURAL")

(d) Street No. Rural Walnut Grove Township
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Ulysses Latham Grant

3. (b) If veteran, name war no

3. (c) Social Security No. no

20. DATE OF DEATH: Month December day 14
year 1943 hour 9 minute 30 a.m.

21. I hereby certify that I attended the deceased from November 14th to December 14th, 1943;
that I last saw him alive on December 13th, 1943;
and that death occurred on the date and hour stated above.

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

6. (b) Name of husband or wife Sally (priest) 6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased October 24 1865
(Month) (Day) (Year)

Immediate cause of death Heart Attack
Arterio Sclerosis

Due to chronic Bronchitis - 2 years

8. AGE: Years 78 Months 1 Days 20 If less than one day hr. min.

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

9. Birthplace Greene County Missouri
(City, town, or county) (State or foreign country)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

10. Usual occupation Farmer

11. Industry or business General Stock & Grain Farmer

12. Name Web Grant

13. Birthplace Monroe County Tenn.
(City, town, or county) (State or foreign country)

14. Maiden name Martha Beck

15. Birthplace Greene County Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. W. T. Grant

(b) Address Walnut Grove Mo R2

17. (a) Burial (b) Date thereof Dec 15-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wagon Creek Cemetery

18. (a) Signature of funeral director W. A. Bism

(b) Address Walnut Grove Mo

19. (a) 12-15-1943 (b) Nelson Murray
(Date received local registrar) (Registrar's signature)

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 J. J. Bartsch (M. D. or other) 12/14/43
Address Walnut Grove Mo Date signed _____

1245 (Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

RECEIVED

Greene County Health Office,

County File No. 44-1-4

Date Filed 1-10-44

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 *James A. Brown*

Licensed Embalmer No. 2664

P. O. Address *Wilmington, N.C.*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *Jan.*
Registrar's No. _____

Registration District No. _____ Primary Registration District No. _____

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

1. PLACE OF DEATH:

(a) County *Greene*
(b) City or town *Rural*
(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

In this community _____ years, months or days)

3. (a) PRINT FULL NAME *Ulysses S. Grant*

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

4. Sex *m* 5. Color of race *w* 6. (a) Single, widowed, married, divorced *on*

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year

7. Birth date of deceased *Oct. 24 - 1861*
(Month) (Day) (Year)

8. AGE: Years *78* Months *1* Days _____ If less than one day _____ 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)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Dec* day *24* year *1943* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____

that I last saw him/her alive on _____, 19____ and that death occurred on the date and hour stated above.

Immediate cause of death *Heart attack*

Due to *Arterio sclerosis* Duration *2 yr.*

Chronic Bronchitis *2 yr.*

Due to *Chronic myocarditis, with possible*

cause of thrombosis

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

Major findings: Of operations *518*

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) Manner of injury _____

23. Signature *J. W. Barber M.D.* (M. D. or other) _____
Address *W. Walnut Street* Date *Jan 16 - 44*

SUPPLEMENTARY

MOTHER FATHER

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

S-42265