

No. 2
8-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 18 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18366

State File No. _____

Registration District No. 233

Primary Registration District No. 6115

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Rural Richland Twp.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
3 Miles East Sikeston!
(If not in hospital or institution, write street number or location)

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

In this community 30 yrs
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott

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

(d) Street No. 3 Miles East Sikeston
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME ENOCH GIBSON GRIGSBY

(b) If veteran, name war NONE

(c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 30
year 1945 hour 7 minute 30 P.M.

21. I hereby certify that I attended the deceased from Mar 2
_____, 19____, to Mar 30, 1945
that I last saw him alive on Mar 27, 1945
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race W 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 JANUARY 18 1871
(Month) (Day) (Year)

Immediate cause of death Coronary Occlusion 3 day

Due to Arterio Sclerosis

Due to _____

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

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

74 2 12 _____ hr. _____ min.

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

10. Usual occupation Retired

Major findings:
Of operations _____

Of autopsy _____

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

11. Industry or business _____

12. Name Henry Grigsby

13. Birthplace La Crosse Kentucky
(City, town, or county) (State or foreign country)

14. Maiden name Susan Fields

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

16. (a) Informant Robert Grigsby

(b) Address Sikeston, Mo.

17. (a) Burial (b) Date thereof Apr 1 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Miss Switzer

18. (a) Signature of funeral director Walter Funeral Home

(b) Address Sikeston, Mo.

19. (a) 5/14/45 (b) L. Lane Lergel
(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? _____

(Specify type of place) _____

23. Signature Howard M. ... (M. D. or other) _____
Address Sikeston Mo. Date signed 5/13/45

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

0
5
6
7

1518

RECEIVED

District Health Office No.

District File Number 545-72

Date Filed 5-15-4

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: *W. Bluff*

Licensed Embalmer No. 4399

P. O. Address *Poplar Bluff*

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. June
Registrar's No. _____

Registration District No. 333

Primary Registration District No. 6115

1. PLACE OF DEATH:

(a) County Scott
(b) City or town Rural Richland sup
(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

Enoch G. Grigsby

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

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

6. (b) Name of husband or wife Was not married
6. (c) Age of husband or wife if alive _____

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years 74 Months 2 Days _____
If less than one day _____ hr. _____ min.

9. Birthplace _____
(City, town, or county) (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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(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 _____ Day _____
Year _____ Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.
Immediate cause of death _____

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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

183le6