U. S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

FILED OCT 27 1945 STANDARD CERTIFICATE OF DEATH

State File No. 33769

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 785

1. PLACE OF DEATH:
(a) County: Greene
(b) City or town: Springfield (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 456 E. Grand (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: 25 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Greene
(c) City or town: Springfield (If outside city or town limits, write "RURAL")
(d) Street No.: 456 E. Grand (If rural, give location)
(e) Citizen of foreign country? ____ (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME: William H. McGrath
3. (b) If veteran, name war: No
3. (c) Social Security No.: No
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Bertha Lee McGrath
6. (c) Age of husband or wife if alive: UNK years
7. Birth date of deceased: April (Month) 9 (Day) 1866 (Year)

8. AGE: Years	Months	Days	If less than one day
79	5	23	____ hr. ____ min.

9. Birthplace: Louisburg (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: Retired
11. Industry or business: Farmer
FATHER
12. Name: James McGrath
13. Birthplace: UNK. (City, town, or county) Pennsylvania (State or foreign country)
MOTHER
14. Maiden name: Jane Hass
15. Birthplace: UNK. (City, town, or county) Germany (State or foreign country)
16. (a) Informant: Mrs. Bertha L. McGrath
(b) Address: Springfield, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10/4/45 (Month) (Day) (Year)
(c) Place: burial or cremation: Maple Park
18. (a) Signature of funeral director: H.H. Lohmeyer
(b) Address: Springfield, Mo.
19. (a) 10-4-45 (Date received local registrar) (b) S. W. E. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 2 year 1945 hour 9 minute 45p. M.
21. I hereby certify that I attended the deceased from Apr 45 to Oct 2 1945 that I last saw h. alive on Oct 1 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Hemorrhage	6 hrs
Due to: Arteriosclerosis	
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) Manner of injury

23. Signature: [illegible] (M. D. or other)
Address: [illegible] Date signed 10-4-45

(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 by me, or by.....

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

working under my personal supervision.

Signed L. Stanley Gorman

Licensed Embalmer No. 3677

P. O. Address Springfield 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.