

STANDARD CERTIFICATE OF DEATH

State File No. 11876

FILED APR 12 1946  
Registration District No. 322

Primary Registration District No. 3071

Registrar's No.

1. PLACE OF DEATH:

(a) County Saline  
(b) City or town Slater  
(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.  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Saline 97  
(c) City or town Slater 1  
(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 John Grandstaff

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

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased May-12-1854  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
92 10 23 hr. min.

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

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name Julius Grandstaff

13. Birthplace Don't know G  
(City, town, or county) (State or foreign country)

14. Maiden name Don't know

15. Birthplace Don't know G  
(City, town, or county) (State or foreign country)

16. (a) Informant Chas Grandstaff

(b) Address Corder Missouri

17. (a) Lexington Mo (b) Date thereof 4/7/1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lexington Mo

18. (a) Signature of funeral director Jones and Salzer

(b) Address Slater Mo

19. (a) April 8, 1946 (b) Mr. Earl C. Metz  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 5th  
year 1946 hour 8/30 P.M. minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Mar 25 1946 to April 5 1946  
that I last saw him alive on April 5 and that death occurred on the date and hour stated above.

Immediate cause of death  
Myocardial Infarction 12 hr.  
Fracture left hip 6 hr.  
Substituted leg 3 yrs

PHYSICIAN

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy None

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 4/7  
(c) Where did injury occur? Fall from bed (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? at home

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

23. Signature W. B. Ledford (M. D. or other) MD  
Address Slater Mo Date signed 4/6/46

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

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 4-11-46

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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 Herman Salzer

Licensed Embalmer No. 1831

P. O. Address Slater 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.

Registration District No. 222

Primary Registration District No. 3071

**1. PLACE OF DEATH:**  
 (a) County Saline State  
 (b) City or town \_\_\_\_\_  
(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** John Bradsteff  
 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 wid  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased May 12 1865  
(Month) (Day) (Year)

8. AGE: Years 92 Months \_\_\_\_\_ 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 April year 1956 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw him/her on \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_

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

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

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

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

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) fell from bed  
 (b) Date of occurrence April 2-56  
 (c) Where did injury occur? Saline Mo.  
(City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
at home of daughter  
(Specify type of place)  
 While at work? yes (e) Means of injury fallen

23. Signature H. E. ... (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

**SUPPLEMENTARY**

ADDITIONAL  
 SUPPLEMENTARY  
 INFORMATION  
 REQUESTED

Duration \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

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

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