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

STANDARD CERTIFICATE OF DEATH

FILED JUN 20 1946

20629

State File No.

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 162

1. PLACE OF DEATH:

(a) County JACKSON

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

(c) Name of hospital or institution:
INDEPENDENCE SANITARIUM & HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 DAYS (Specify whether years, months or days)

In this community 27 YEARS

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON

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

(d) Street No. 810 WEST WHITE OAK
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME CHARLES U. GRANT

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 WIDOWER

6. (b) Name of ~~husband or~~ wife PHOEBE J. GRANT

6. (c) Age of husband or wife if alive XXXXXXX years

7. Birth date of deceased 11 (Month) 20 (Day) 1864 (Year)

8. AGE: Years 81 Months 5 Days 11 If less than one day ___ hr. ___ min.

9. Birthplace BAY PORT (City, town, or county) MICH (State or foreign country)

10. Usual occupation RETIRED

11. Industry or business CONTRACTOR & BUILDING

FATHER
12. Name CHARLES E. GRANT
13. Birthplace BAY PORT (City, town, or county) MICH (State or foreign country)

MOTHER
14. Maiden name MARY E. GRAVES
15. Birthplace NO RECORD (City, town, or county) (State or foreign country)

16. (a) Informant MRS. S. A. THIEL

(b) Address 818 N. COTTAGE

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5-3-46 (Month) (Day) (Year)

(c) Place: burial or cremation MOUND GROVE

18. (a) Signature of funeral director [signature]

(b) Address 815 W. MAPLE AVE.

19. (a) May 14, 1946 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 1 year 1946 hour 7 minute 05 P.M.

21. I hereby certify that I attended the deceased from April 19, 1946 to May 1, 1946 that I last saw him alive on April 1, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Left arm and leg paralysis — Duration

Due to Cerebral hemorrhage

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy none

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) NO

(b) Date of occurrence

(c) Where did injury occur? none (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? none (Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M. D. or coroner)

Address Date signed May 2, 1946

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(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 X X, Registered Apprentice No. X X, working under my personal supervision.

Signed [illegible]

Licensed Embalmer No. 3156

P. O. Address Independence, [illegible]

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.