

S. No. 2  
OM-5-43  
v. 5-17-39  
X36671

DEPARTMENT OF COMMERCE  
BUREAU OF PUBLIC HEALTH

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

26312

State File No. \_\_\_\_\_

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 973

1. PLACE OF DEATH:

(a) County Buchanan

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

(c) Name of hospital or institution:  
508 North 5th  
(If not in hospital or institution, write street number or location)

(d) Length of stay: 60 Years (Specify whether in this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan //

(c) City or town St Joseph /  
(If outside city or town limits, write "RURAL")

(d) Street No. 508 North 5th 7  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mrs Grace Gertrude Elrod

3. (b) If veteran, name war No

3. (c) Social Security No. No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 26  
year 1946 hour 10 minute 20 A. M.

21. I hereby certify that I attended the deceased from 8/26/46 to 8/26/46, 19\_\_\_\_, to 8/26/46, 19\_\_\_\_; that I last saw her alive on 8/26/46, 19\_\_\_\_; and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Edwin 6. (c) Age of husband or wife if alive 21 years 1879 (Day) (Year)

7. Birth date of deceased: July 21 1879  
(Month) (Day) (Year)

Immediate cause of death coronary occlusion 0 hrs. Duration

Due to Chronic hypocalcemia 10 yrs.

Due to Chronic hypertension 10 yrs.

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

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

<u>67</u>	<u>1</u>	<u>5</u>	_____ hr. _____ min.
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Major findings:  
Of operations 938

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

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

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

10. Usual occupation Housewife

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? 0

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

23. Signature Wm. Jacobson M.D.  
Address Kirkpatrick Bldg. Date signed 8/26/46

MOTHER FATHER {

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

12. Name Hezekiah Watson

13. Birthplace \_\_\_\_\_ Ky  
(City, town, or county) (State or foreign country)

14. Maiden name Lilly Agée

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

16. (a) Informant Mrs Josephine Kellogg

(b) Address St Joseph, Mo.

17. (a) Burial (b) Date thereof 8-29-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Savannah Cemetery

18. (a) Signature of funeral director Fleeman & Son Inc.

(b) Address St Joseph, Mo.

19. (a) Aug. 31, 1946 (b) H. J. [Signature]  
(Date received local registrar) (Registrar's signature)

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

25158

051 3  
1946

**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 N.E.~~

working under my personal supervision.

Signed

*Robert H. Yapple*

Licensed Embalmer No. 3308

P. O. Address. St. Joseph, 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.