

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 889

FILED NOV 21 1946  
Registration District No. \_\_\_\_\_

Primary Registration District No. 2000

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

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: St. John Hosp.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Day  
(Specify whether in this community \_\_\_\_\_ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39

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

(d) Street No. Route # 9  
(If rural, give location)

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

3. (a) PRINT FULL NAME John Wesley Grisham

3. (b) If veteran, name war No

3. (c) Social Security No. \_\_\_\_\_

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

6. (b) Name of husband or wife May Grisham 6. (c) Age of husband or wife if alive 1882 years

7. Birth date of deceased Dec. 10 1882  
(Month) (Day) (Year)

8. AGE: Years 63 Months 10 Days 26  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Elk Creek Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

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

MOTHER FATHER { 12. Name Austin Grisham

13. Birthplace Unknown Tennessee  
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Nall

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

16. (a) Informant Mrs. May Grisham

(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof Nov. 10, 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cabool, Missouri

18. (a) Signature of funeral director H.H. Lohmeyer

(b) Address Springfield, Mo.

19. (a) 11-9-46 (b) W.E. Handley M.D.  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 6  
year 1946 hour 12 minute Noon M.

21. I hereby certify that I attended the deceased from 11-5-46 to 11/6/46  
that I last saw him alive on 11-6-46 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis

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

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

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

Duration

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? 0

While at work? \_\_\_\_\_ (Specify type of place)  
Means of injury \_\_\_\_\_  
23. Signature W.E. Handley (M. D. or other) M.D.  
Address Springfield Mo. Date signed 11/7/46

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 Roy H. Mercer, Jr.  
Licensed Embalmer No. 4432  
P. O. Address Springfield, MD

**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.**