S. No. 2
12-45
5-17-39
X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 13 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31759

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 120

1. PLACE OF DEATH:
(a) County ~~Putnam~~ Livingston
(b) City or town Chillicothe Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Chillicothe City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County ~~R~~ Livingston 59
(c) City or town Chillicothe Mo 1
(If outside city or town limits, write "RURAL")
(d) Street No. 2
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Bertha May Grindstaff
3. (b) If veteran, name war
5. (c) Social Security No.
4. Sex FE 1
5. Color or race W
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Simon H. Grindstaff
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Nov (Month) 11 (Day) 1881 (Year)

8. AGE: Years 65 Months 9 Days 27 If less than one day hr. min.

9. Birthplace Putnam County (City, town, or county) 0 (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER
12. Name Lewis Rogers 0
13. Birthplace Sullivan Co (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Josephine Perkins
15. Birthplace Unknown (City, town, or county) 4 (State or foreign country)
16. (a) Informant E. J. Grindstaff 1
(b) Address Chillicothe
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 (Month) 10 (Day) 47 (Year)
(c) Place: burial or cremation Hamilton
18. (a) Signature of funeral director Riggs & Son
(b) Address Milan Mo
19. (a) Sept-9-47 (Date received local registrar) (b) Frances B Neill (Registrar's signature) 1

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 8
year 1947 hour 4 minute 15 P.M.

21. I hereby certify that I attended the deceased from June 1946, to Sept 8, 1947;
that I last saw her alive on Sept 8, 1947;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cardiac Decompensation	5 days
Due to Coronary sclerosis	
Due to Hypertensive Heart Disease	
Other conditions none (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy none noted	

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

23. Signature Joseph A. Conrad (M. D. or other) M.D.
Address Chillicothe, Mo Date signed Sept 8 47

(Licensed Embalmer's Statement on Reverse Side)

DISTRICT HEALTH OFFICE
Cameron, Mo.

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. Russell Rogers

Licensed Embalmer No. 3792

P. O. Address. Milan, 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.

S. No. 2B
5M—3-45
I X43880

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Cert

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 120

1. PLACE OF DEATH:

(a) County Livingston

(b) City or town Chillicothe
(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)

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

3. (a) PRINT FULL NAME Bertha M. Grundstuff

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

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 years

7. Birth date of deceased Nov. 11 1882
(Month) (Day) (Year)

8. AGE: Years 65 Months 9 Days 29 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept 8 1947 year hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
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) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

S-31759