

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 22 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

44511

State File No.

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

- (a) County Ozark
(b) City or town Rural- Jasper Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution 81 yrs (Specify whether years, months or days)
In this community

3. (a) PRINT FULL NAME William Grace

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife --- 6. (c) Age of husband or wife if alive 14 years (Month) (Day) (Year)

7. Birth date of deceased. August 14 1866
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
81 3 15 hr. min.9. Birthplace Ozark County Missouri
(City, town, or county) (State or foreign country)10. Usual occupation Farmer11. Industry or business ---

MOTHER FATHER { 12. Name Henry Grace 13. Birthplace Missouri
14. Maiden name Mary Click 15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant J. E. Smith
(b) Address Isabella Missouri
17. (a) Burial (b) Date thereof 11-30-47
(Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director Isabella, Missouri(b) Address Gainesville, Missouri19. (a) 1-29-48 (b) Mary F. Johnson
(Received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Ozark
(c) City or town Isabella- rural
(If outside city or town limits, write "RURAL")
(d) Street No. --- (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country ---

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 29
year 1947 hour 4 minute A M.21. I hereby certify that I attended the deceased from ---, 19---, to ---, 19---;that I last saw him alive on ---, 19---, and that death occurred on the date and hour stated above.Immediate cause of death? Cardiac Resumption of life
Duration 2 1/2 hrs.Due to ---Due to Natural Cause

Other conditions (Include pregnancy within 3 months of death)

Major findings: Found dead in bed
Of operations 42M 11-29-47Of autopsy 95C

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) (c) Means of injury

23. Signature M. J. Haerian (M. D. or other) Coroner
Address Gainesville Date signed 11/30/47

RECEIVED

District Health Officer No. 6;

District File Number 148-119

Date Filed 1-19-48

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

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1. PLACE OF DEATH:

- (a) County Garh
(b) City or town Rural
(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

3. (b) If veteran,
-
- name war

3. (c) Social Security
-
- No.

4. Sex

M

race

W

divorced

5

6. (b) Name of husband or wife

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

7. Birth date of deceased

(Month)

(Day)

(Year)

8. AGE:

Years

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

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)

(Burial, cremation, or removal)

- (b) Date thereof

(Month)

(Day)

(Year)

- (c) Place: burial or cremation

13. (a) Signature of funeral director

- (b) Address

19. (a)

(Date received local registrar)

- (b) Mary F. Johnson

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State MO (b) County Garh
(c) City or town Rural
(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
- 20
- Year
- 1944
- hour
- 9
- minute
- 15
- M.

21. I hereby certify that I attended the deceased from
- 1944
- to
- 1944
- , that I last saw him
- alive
- on
- 1944
- and that death occurred on the date and hour stated above.

- Immediate cause of death
- Cardiac

- Duration
- 10 y

- 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?

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

23. Signature
- M. J. Holman
- Date signed
- 1944

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

S-44511