

Registration District No. 02

Primary Registration District No. 3012

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

1. PLACE OF DEATH:

(a) County Cooper

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

(c) Name of hospital or institution:  
St. Joseph  
(If not in hospital or institution, write street number or location) 0

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

3: (a) PRINT FULL NAME Joyce Eileen Grabe

3: (b) If veteran name war \_\_\_\_\_

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

4. Sex Female race White

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 \_\_\_\_\_ years

7. Birth date of deceased: May 4 - 1948  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. 30 min.

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

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER { 12. Name William M. Grabe

13. Birthplace Howard Co. Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Aileen Sellen

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

16. (a) Informant W. M. Grabe

(b) Address Franklin Mo.

17. (a) Residual (b) Date thereof 5/5/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Joseph

18. (a) Signature of funeral director C. S. Newland

(b) Address New Franklin Mo.

19. (a) 5-6-48 (b) W. Cooper  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Howard 45

(c) City or town Rural Franklin Dist.  
(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 May day 4  
year 1948 hour \_\_\_\_\_ minute 7 P.M.

21. I hereby certify that I attended the deceased from 6:20 P.M.  
5/4, 1948, to 5/4, 1948;

that I last saw her alive on 5/4, 1948;  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia, Acute, Bronchial infection

Due to Arteriosclerosis in mother

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

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

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

Of autopsy yes

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 0

23. Signature Donald N. Morgan (M. D. or other) MD.  
Address Boonville Mo. Date signed 5/6/48

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed \_\_\_\_\_

5-10-48

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**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.**