

Registration District No. 187

Primary Registration District No. 5038

Registrar's No. 58

1. PLACE OF DEATH:

(a) County: Linn
 (b) City or town: Brookfield
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 202 Grant St /
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution: 11 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo
 (b) County: Linn
 (c) City or town: Brookfield
 (If outside city or town limits, write "RURAL")
 (d) Street No.: 202 Grant St
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country:

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3. (a) PRINT FULL NAME: SAMUEL DICKINSON GRANT

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

4. Sex: M
 5. Color or race: B
 6. (a) Single, widowed, married, divorced: M
 6. (b) Name of husband or wife: Bertie Grant
 6. (c) Age of husband or wife if alive: 51 years
 7. Birth date of deceased: Jan - 5 - 1871 (Month) (Day) (Year)

8. AGE: Years 77, Months 5, Days 24, If less than one day _____

9. Birthplace: Linn Co Mo (City, town, or county) (State or foreign country)

10. Usual occupation: Retired Farmer

11. Industry or business:
 12. Name: John Grant
 13. Birthplace: Howell Co Mo (City, town, or county) (State or foreign country)
 14. Maiden name: Maggie Morrow
 15. Birthplace: SPI Ohio (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Bertie Grant

(b) Address: Brookfield, Missouri

17. (a) Burial (Burial, cremation, or removal): Burial
 (b) Date thereof: July - 1, 1948 (Day) (Year)

(c) Place: burial or cremation: Rose Hill

18. (a) Signature of funeral director: Rose Hill Funeral Home

(b) Address: Brookfield Mo

19. (a) Date received local registrar: 7-2-48
 (b) Registrar's signature: [Signature]

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 29 year 1948 hour 9 minute 30 M.

21. I hereby certify that I attended the deceased from May 15, 1948, to June 25, 1948, that I last saw him alive on June 25, 1948, and that death occurred on the date and hour stated above.

Immediate cause of death: Acute Cardiac Dilatation 1/2 hr.

Other conditions: Obus Casei yowa of Prostate Gland 1 1/2 yr.

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

Major findings: Of operation: Caseixans of Prostate
 Of autopsy: 51

PHYSICIAN

Underline the cause of 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? _____ Means of injury _____

23. Signature: Roy P. Haley (M. D. or other) _____

Address: Brookfield Mo Date signed: 6-30-48

MOTHER FATHER

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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

J. A. Blacklock

Licensed Embalmer No. *2246*

P. O. Address *Brookfield*

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.