

FILED MAR 26 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

8389
1003

BIRTH NO.		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>1003</u>	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. LENGTH OF STAY (In this place) <u>40 Yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>3807 Bellefontaine</u>				d. STREET ADDRESS (If rural, give location) <u>3807 Bellefontaine</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>Bertha</u>		b. (Middle) <u>Elizabeth</u>		c. (Last) <u>Grant</u>	
4. DATE OF DEATH		(Month) <u>Mar.</u>		(Day) <u>3</u>		(Year) <u>1949</u>	
5. SEX <u>Fe /</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Dec. 31, 1883</u>	
9. AGE (In years last birthday) <u>65</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13a. FATHER'S NAME <u>D. Lawson Gordy</u>		13b. MOTHER'S MAIDEN NAME <u>Sallie Ann Maxwell</u>		14. NAME OF HUSBAND OR WIFE <u>M.E. Grant</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <u>M.E. Grant,</u>		ADDRESS <u>Kansas City, Mo.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>cerebral degeneration</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>cardiac failure</u> DUE TO (c) <u>arteriosclerotic heart disease</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>4200</u>				INTERVAL BETWEEN ONSET AND DEATH <u>14 1/2 - 3 mos</u> <u>3 days</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2-27</u> , 19 <u>49</u> , to <u>3-3</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>3-3</u> , 19 <u>49</u> , and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Leo M. Muller</u>		(degree or title) <u>M.D.</u>		23b. ADDRESS <u>3548 Indiana</u>		23c. DATE SIGNED <u>3-3-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Mar. 3, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Odessa, Mo. Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Odessa, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>3-4-49</u>		REGISTRAR'S SIGNATURE <u>Thereldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Thuman - Sparks & Odessa, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

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.....

..... Student Embalmer No.

working under my personal supervision.

Signed.....

William T. Sparks

Signed.....
Student Embalmer

Licensed Embalmer No. *14431*

P. O. Address *Oessa, 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: