

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED APR 20 1949

No. 300
10.48

BIRTH NO. _____		REG. DIST. NO. <u>47</u>		PRIMARY REG. DIST. NO. <u>3008</u>		Registrar's No. <u>122</u>			
1. PLACE OF DEATH a. COUNTY <u>Callaway</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Pettis</u>					
b. CITY (If outside corporate limits, write RURAL and give township) <u>Fulton</u>				c. CITY (If outside corporate limits, write RURAL and give township) <u>Sedalia</u>					
c. LENGTH OF STAY (in this place) <u>4 mo</u>				d. STREET ADDRESS (If rural, give location) <u>7</u>					
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital No 1</u>				d. STREET ADDRESS (If rural, give location) <u>1</u>					
3. NAME OF DECEASED (Type or Print) <u>Grace</u>			a. (First)		b. (Middle) <u>-</u>		c. (Last) <u>Irwin</u>		
4. DATE OF DEATH		(Month) <u>4</u>		(Day) <u>14</u>		(Year) <u>1949</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>Apr. 10-1896</u>			
9. AGE (In years last birthday) <u>55</u>		IF UNDER 1 YEAR Months <u>0</u>		IF UNDER 1 YEAR Days <u>4</u>		IF UNDER 1 HRS. Hours <u></u> Min. <u></u>			
10a. 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>Mo</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>			13a. FATHER'S NAME <u>William Rayl</u>		13b. MOTHER'S MAIDEN NAME <u>Nancy White</u>		14. NAME OF HUSBAND OR WIFE <u>Arthur Irwin</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <u>Hospital Records, Fulton, Mo</u>			ADDRESS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) <u>Cerebral Arteriosclerosis</u>				II. OTHER SIGNIFICANT CONDITIONS <u>Cardiac hypertrophy</u>				3.34A	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hemorrhage into the cerebral 4th ventricle</u> DUE TO (c) <u></u>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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>April 11-1949</u> , to <u>4-14-49</u> , 19 <u> </u> , that I last saw the deceased alive on <u>4-14-49</u> , 19 <u> </u> , and that death occurred at <u>8:50 P</u> m., from the causes and on the date stated above.									
23a. SIGNATURE <u>M. J. Miller</u> (Degree or title)				23b. ADDRESS <u>State Hospital, Fulton, Mo</u>			23c. DATE SIGNED <u>4-14-49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>April-16-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Sweet Springs Mo.</u>			
DATE REC'D BY LOCAL REG. <u>April-14-1949</u>		REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u>		426		25. FUNERAL DIRECTOR'S SIGNATURE <u>Thallice Funeral Home, Fulton Mo</u> ADDRESS			

(Licensed Embalmer's Statement on Reverse Side)

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

Date Filed APR 19 1949

District File Number

District Health Officer No. 9

APR 25 1949

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.

Student _____
Student Embalmer

Signed Daniel C. Browning

Licensed Embalmer No. 2724

P. O. Address Fullers rd

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.