

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22660**

FILED AUG 2 1950

BIRTH NO. _____ REG. DIST. NO. **3** PRIMARY REG. DIST. NO. **4011** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Atchison		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE Missouri b. COUNTY Atchison	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Watson		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Watson 0090	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) none	
d. FULL NAME OF HOSPITAL OR INSTITUTION none			

3. NAME OF DECEASED (Type or Print)	a. (First) Marie	b. (Middle) Ellen	c. (Last) Grebe	4. DATE OF DEATH (Month) (Day) (Year) 6/25/1950
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 5/24/1888	9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months 1 Days 1	IF UNDER 24 HRS. Hours Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper	10b. KIND OF BUSINESS OR INDUSTRY X	11. BIRTHPLACE (State or foreign country) Shandoah, Iowa	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME August Hall	13b. MOTHER'S MAIDEN NAME Laura Cunningham	14. NAME OF HUSBAND OR WIFE Eddie Grebe
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) no	17. INFORMANT'S SIGNATURE OR NAME Eddie Grebe.	ADDRESS Watson, Mo.,
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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		INTERVAL BETWEEN ONSET AND DEATH 350X
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Parkinson disease		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) None DUE TO (c) None		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION None	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) no	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **June 1 - 1950**, to **6/25, 1950**, that I last saw the deceased alive on **June 24, 1950**, and that death occurred at **59** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) J. A. Gray M.D.	23b. ADDRESS Watson Mo.	23c. DATE SIGNED 6/25/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE June 27-50	24c. NAME OF CEMETERY OR CREMATORY Linden	24d. LOCATION (City, town, or county) (State) Rock Port. Mo.,
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DATE REC'D BY LOCAL REG. June 27-50	REGISTRAR'S SIGNATURE J. A. Gray	25. FUNERAL DIRECTOR'S SIGNATURE Bartholomew Mortuary,	ADDRESS Rockport. Mo.,
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
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.....

Student Embalmer No.

working under my personal supervision.

Signed.....

Gary Bartholomew

Signed.....
Student Embalmer

Licensed Embalmer No. 3173

P. O. Address Rock Port, 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.