

FILED JUL 19 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23911

State File No. _____

BIRTH NO. _____		REG. DIST. NO. <u>274</u>		PRIMARY REG. DIST. NO. <u>3052</u>		Registrar's No. <u>2657</u>	
1. PLACE OF DEATH a. COUNTY <u>Pettis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>			
b. CITY OR TOWN <u>Sedalia</u>		c. LENGTH OF STAY (in this place) <u>LIFE</u>		c. CITY OR TOWN <u>Sedalia</u>		d. Is residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>301 E. 6th</u>				e. STREET ADDRESS (If rural, give location) <u>301 E. 6th</u> <u>08090</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Columbia</u> b. (Middle) <u>C.</u> c. (Last) <u>Grinstead</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>JULY 15 1954</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Sept 8 1867</u>		9. AGE (In years last birthday) <u>86</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 4 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Mayslick Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>G. G. Berry</u>			13b. MOTHER'S MAIDEN NAME <u>Elizabeth S. S. S.</u>		14. NAME OF HUSBAND OR WIFE <u>Samuel Grinstead</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Geo. G. Grinstead - 301 E. 6</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* <u>Pulmonary Hemorrhage</u> ANTECEDENT CAUSES <u>Arterio Sclerosis & bronchial varicosities</u> Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH _____
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>4500</u>				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) _____		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>February 1954</u> to <u>July 13, 1954</u> that I last saw the deceased alive on <u>7-13, 1954</u> , and that death occurred at <u>7:30 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>W. Boyer M.D.</u>				23b. ADDRESS <u>Sedalia Mo</u>		23c. DATE SIGNED <u>7-16-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>7-17-54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill</u>		24d. LOCATION (City, town, or county) (State) <u>Sedalia Mo</u>		
DATE REC'D BY LOCAL REG. <u>7-16-54</u>		REGISTRAR'S SIGNATURE <u>Lavinia Boone</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>M. Laughlin</u>		ADDRESS <u>Boon Sedalia 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..

Student.....
Signature of Student Embalmer

Signed *K.P. McLeary*.....

Licensed Embalmer No. *315*.....

P. O. Address *Sedalia*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.