

0.300
0.48
0

FILED DEC 20 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40614**

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **1101-A**

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Texas	
b. CITY (If outside corporate limits, write RURAL and give township) Springfield		c. CITY OR TOWN Cabool	d. Is Residence within limits of a city or incorporated town? 1070 Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Johns Hospital		STREET ADDRESS (If rural, give location) <input type="checkbox"/> ADDRESS	

3. NAME OF DECEASED (Type or Print)	a. (First) PAUL	b. (Middle) SILAS	c. (Last) GRANT	4. DATE OF DEATH (Month) (Day) (Year) Dec. 2, 1954
-------------------------------------	------------------------	--------------------------	------------------------	--

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 17, 1887	9. AGE (In years last birthday) 67 if UNDER 1 YEAR Months Days if UNDER 24 HRS. Hours Mins.
--------------------	-------------------------------	---	--------------------------------------	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumberman	10b. KIND OF BUSINESS OR INDUSTRY Lumber	11. BIRTHPLACE (City and State or Foreign Country) Cabool, Missouri	12. CITIZEN OF WHAT COUNTRY? U. S. A.
--	---	--	--

13a. FATHER'S NAME Silas Wright Grant	13b. MOTHER'S MAIDEN NAME Margaret	14. NAME OF HUSBAND OR WIFE Mildred Grant
--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes World War I	16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT'S SIGNATURE OR NAME Mrs. Mildred Grant ADDRESS Cabool, Mo.,
---	--	---

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 4 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Thrombosis middle meningeal artery, left.		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral arteriosclerosis DUE TO (c)		
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	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) Springfield, Greene, Mo.
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 **Nov 30, 1954**, to **Dec 2, 1954**, that I last saw the deceased alive on **Dec 2, 1954**, and that death occurred at **3:45 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) M. D.	23b. ADDRESS Springfield, Missouri	23c. DATE SIGNED 12/3/1954
---	---	-----------------------------------

24a. BURIAL CREMATION REMOVAL (Specify) Removal	24b. DATE 12/3/1954	24c. NAME OF CEMETERY OR CREMATORY Cabool	24d. LOCATION (City, town, or county) (State) Missouri
--	----------------------------	--	---

DATE REC'D BY LOCAL REG. 12-14-54	REGISTRAR'S SIGNATURE Robert Williamson	25. FUNERAL DIRECTOR'S SIGNATURE Harry [Signature] ADDRESS Springfield, Mo.,
--	--	--

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING INK—MISSOURI A PERMANENT RECORD

DEC 31 1955

FEB 3 1955

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.....
Licensed Embalmer No. 4519

P. O. Address Springfield

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.