

Health, welfare, public service

FILED JAN 20 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2488

STATE FILE NUMBER

Registration District No. 310 Primary Registration District No. 6057 Registrar's No. 15

1. PLACE OF DEATH a. COUNTY <u>Saint Charles</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>River - Saint Charles twsp</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Saint Charles twsp.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>R.R. # 3</u>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <u>R.R. # 3</u> <u>9924 on Farm</u> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>E.</u> Last <u>Grounds</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>11</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>March 18, 1877</u>	9. AGE (In years last birthday) <u>70</u> IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>foundry work</u>		11. BIRTHPLACE (City and state or country) <u>Cornwall, Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Adam E. Grounds</u>		13b. MOTHER'S MAIDEN NAME <u>Margaret Rhodes</u>	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>487-20-92-97</u>	
17. INFORMANT <u>Charles, Grounds, Flat River, Mo.</u>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>suicide</u>					INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>F ut single barrel shotgun to head and fired</u>			
20c. TIME OF INJURY Hour <u>12:30</u> Month <u>1</u> Day <u>11</u> Year <u>58</u>					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>residence (trailer)</u>		20f. CITY, TOWN, OR LOCATION <u>Saint Charles, Mo.</u>	
		COUNTY <u>St. Charles Co.</u>		STATE	
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Maris Muechberg Crown</u>		(Degree or title) <u>3</u>		22b. ADDRESS <u>Wentzville Mo</u>	
				22c. DATE SIGNED <u>Jan 11 - 1958</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Jan. 14, 1958</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rhodes Chapel Cemetery</u>	
				23d. LOCATION (City, town, or county) (State) <u>Fredricktown, Missouri</u>	
24. FUNERAL DIRECTOR <u>Caldwell & Sons, Flat River, Mo.</u>		ADDRESS		25. DATE RECD. BY LOCAL REG. <u>JAN. 11 - 58</u>	
				26. REGISTRAR'S SIGNATURE <u>Maureen Wilson</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

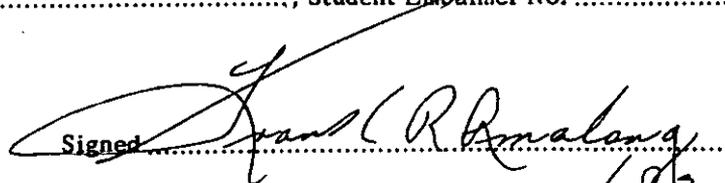
JAN 29 1958

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. 4832

P. O. Address St. Charles

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.