

Health,
& Welfare
Public
Service
640
S. 300
1-57

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-024830

STATE FILE NUMBER
388

FILED JUL 16 1958 Registration District No. 53 Primary Registration District No. Registrar's No. 388

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>California</u> b. COUNTY <u>Ingo</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cape Girardeau</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>Big Pine Calif.</u> ⁸⁰⁴⁰ |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Southeast Hospital</u> | | Length of stay in 1b <u>3 mo.</u> | d. STREET ADDRESS (If outside, give location) <u>396A Cornell</u> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Ara May Grant</u> | | | 4. DATE OF DEATH Month Day Year <u>July 1 1958</u> |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> * 2 DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 16 1874</u> |
| 9. AGE (In years last birthday) <u>84</u> | | IF UNDER 1 YEAR Months <u>1</u> Days <u>15</u> | IF UNDER 24 HRS. Hours <u>15</u> Min. |
| 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 <u>None</u> | 11. BIRTHPLACE (City and state or country) <u>Morley Mo.</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | | 13a. FATHER'S NAME <u>Drury Vaughan</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>Anna Estes</u> | | 14. NAME OF HUSBAND OR WIFE <u>Deceased John F Grant</u> | |
| 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>no</u> | 17. INFORMANT Address <u>Mrs. John Spence Morehouse Mo.</u> |
| 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>Arteriosclerotic Heart Disease</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Generalized Arteriosclerosis</u> | | | <u>10 years</u> |
| DUE TO (c) <u>4200</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Ulcerated Stomach Nerve - Bowel obstruction</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION | COUNTY STATE |
| 21. I attended the deceased from <u>May 23, 1958</u> , to <u>July 1, 1958</u> and last saw her alive on <u>July 1, 1958</u> Death occurred at <u>3:30 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>Dr. Morehouse MD</u> | | 22b. ADDRESS <u>24 N. Sprigg Cape Gir., Mo.</u> | 22c. DATE SIGNED <u>July 3-58</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>7-3-1958</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u> | 23d. LOCATION (City, town, or county) (State) <u>Cape Girardeau Mo.</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>Brinkopf Howell, Cape Gir Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>July 10, 1958</u> | 26. REGISTRAR'S SIGNATURE <u>Mr. Homer E. Cooper</u> |

All diseases in Part I must be causally related.
 Secondary conditions, etc., must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION

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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.

Student
Signature of Student Embalmer

Signature *Deeth H. Ross*

Licensed Embalmer No. *4984*

P. O. Address *Cape Girardeau*

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.