

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-028188

STATE FILE NUMBER

FILED SEP 2 1958

Registration District No. 38

Primary Registration District No. 3006

Registrar's No. 371

S. 300
1-57

1. PLACE OF DEATH a. COUNTY Boone		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Saline	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Columbia, Missouri		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Slater 09710 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Univ. of Missouri		Length of stay in lb 8 days	d. STREET ADDRESS (If outside, give location) 420 Blackmore Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Frank Middle George Last Grapperhaus			4. DATE OF DEATH Month August Day 25 Year 1958		
--	--	--	--	--	--

5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-3-93	9. AGE (In years as of birthday) 65	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
--------------------	-------------------------------	---	-----------------------------------	--	---	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Illinois	12. CITIZEN OF WHAT COUNTRY? USA
--	-----------------------------------	---	--

13a. FATHER'S NAME Frank Grapperhaus	13b. MOTHER'S MAIDEN NAME Francis Gobel	14. NAME OF HUSBAND OR WIFE Teresa Grapperhaus
--	---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown	16. SOCIAL SECURITY NO.	17. INFORMANT Hospital Records	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) Laceration of brain, right temporal lobe, extensive 9 days		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Fracture, skull, extensive, involving right parietal right temporal, right sphenoid and left frontal bones 9 days		
DUE TO (c) Trauma		902845 9 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Coronary arteriosclerosis and recent myocardial infarction		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
--	--	---

20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Unknown	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Apparent fall. Was found at base of forty foot cliff
--	---

20c. TIME OF INJURY Hour Month, Day, Year unknown 8-16-58	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Countryside	20e. CITY, TOWN, OR LOCATION Near Glasgow	COUNTY Howard	STATE Mo.
---	--	---	-------------------------	---------------------

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.) Countryside	20f. CITY, TOWN, OR LOCATION Near Glasgow	COUNTY Howard	STATE Mo.
--	--	---	-------------------------	---------------------

21. I attended the deceased from Death occurred at **1:00 PM** on **8-16-58** and last saw her alive on _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE W. P. Perna, M. D.	22b. ADDRESS Univ. of Missouri Medical Center	22c. DATE SIGNED 8-25-58
---	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Aug 29 1958	23c. NAME OF CEMETERY OR CREMATORY Salisbury Cemetery	23d. LOCATION (City, town, or county) (State) Salisbury Mo
--	---------------------------------	---	--

24. FUNERAL DIRECTOR HILL BROS FUNERAL HOME	ADDRESS SLATER MO	25. DATE RECD. BY LOCAL REG. Aug 26, 1958	26. REGISTRAR'S SIGNATURE Mrs R.E. Palmer
---	-----------------------------	---	---

(Licensed Embalmer's Statement on Reverse Side)

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

31

SEP 14 1962

SEP 23 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 *[Handwritten Signature]*

Licensed Embalmer No. *4425*

P. O. Address *[Handwritten Address]*

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.