

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-033936  
STATE FILE NUMBER

FILED SEP 30 1958 Registration District No. 316 Primary Registration District No. 6075 Registrar's No. 364

300  
1-57

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1. PLACE OF DEATH a. COUNTY <b>St. Francois</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Francois</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Francois Township</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Cantwell</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Hospital No. 4</b>		Length of stay in 1b <b>9 days</b>	d. STREET ADDRESS (If outside, give location) <b>Not Given</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>BESSIE</b> Middle <b>CORA</b> Last <b>GRAYSON</b>			4. DATE OF DEATH Month <b>September</b> Day <b>6</b> Year <b>1958</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 3, 1895</b>	9. AGE (In years last birthday) <b>63</b>	IF UNDER 1 YEAR Months <b>8</b> Days <b>3</b> IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Iron County, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
13a. FATHER'S NAME <b>Mathew Hurt</b>		13b. MOTHER'S MAIDEN NAME <b>Jennie Fitzgerald</b>		14. NAME OF HUSBAND OR WIFE <b>Halter Grayson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT Address <b>Records, St. Hospital No. 4, Farmington, Mo.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Inanition</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cerebral Thrombosis</b>				<b>2 weeks</b>	
DUE TO (c) <b>Hypertensive Cardio-Vascular Renal Disease</b>				<b>6 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>442X</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <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 <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 <b>August 29, 1958</b> to <b>September 6, 1958</b> and last saw her alive on <b>September 6, 1958</b> Death occurred at <b>1:45 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>J. L. Brennan M.D.</b>			22b. ADDRESS <b>State Hospital No. 4 Farmington, Missouri</b>		22c. DATE SIGNED <b>9-6-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Sept. 9, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parkview Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Farmington, Missouri</b>
24. FUNERAL DIRECTOR <b>C.Z. Boyer &amp; Son, Desloge, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Sept. 6, 1958</b>		26. REGISTRAR'S SIGNATURE <b>Esther Rudloff</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.  
 Secondary causes may be listed only if they are not mentioned in Part I. No symptoms will be stated.

**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 *D. T. Boyer* .....  
Licensed Embalmer No. *3666* .....  
P. O. Address *Deer Lodge* .....

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.