

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038775
STATE FILE NUMBER

FILED DEC 4 1958 Registration District No. 10 Primary Registration District No. 3002 Registrar's No. 255

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Audrain</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Montgomery</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mexico</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Wellsville</u> <u>0700</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Audrain County</u>		Length of stay in lb <u>3 days</u>	d. STREET ADDRESS (If outside, give location) <u>409 First St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>EFFIE</u> Middle <u>BLANCHE</u> Last <u>GRANT</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>20</u> Year <u>1958</u>	
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5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 19, 1895</u>	9. AGE (In years last birthday) <u>63</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u>1</u> Min. <u></u>
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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>at Home</u>	11. BIRTHPLACE (City and state or country) <u>Simpson, Ill.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Charles Murrie</u>	13b. MOTHER'S MAIDEN NAME <u>Annie Simpson</u>	14. NAME OF HUSBAND OR WIFE <u>Roscoe Grant</u>
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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>-</u>	17. INFORMANT <u>Roscoe Grant, Wellsville, Mo.</u>	Address
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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>Myocardial Failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Hypertension Heart disease</u>	<u>same</u>	
	DUE TO (c) <u>Essential Hypertension</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>443X</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>

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.)
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20c. TIME OF INJURY Hour <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>

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
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21. I attended the deceased from March 1957 to Nov 20-58 and last saw ^{her} _{him} alive on Nov 20-58
Death occurred at 5:30 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Harold Laneford M.D.</u>	22b. ADDRESS <u>Union Mo</u>	22c. DATE SIGNED <u>11-23-58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>11/23/1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wellsville City</u>	23d. LOCATION (City, town, or county) (State) <u>Wellsville, Missouri</u>
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24. FUNERAL DIRECTOR <u>W B Hills</u>	ADDRESS <u>Wellsville, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Nov 23-1958</u>	26. REGISTRAR'S SIGNATURE <u>Blanche Neely</u>
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(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc., must use only standard non-manufacture in Item 18. No symptoms will be listed. All diseases in Part I must be causally related.

HA ROL D. W. FRANKFORD, MD
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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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

Signed *Howard F. Myers*

Licensed Embalmer No. *4494*
P. O. Address *Wellsville*

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.