

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-043170

STATE FILE NUMBER

FILED JAN 9 1959 Registration District No. 10 Primary Registration District No. 3002 Registrar's No. 277

1. PLACE OF DEATH a. COUNTY Audrain		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Boone	
b. CITY (If outside corporate limits, give TOWNSHIP only) Mexico		c. CITY OR TOWN Centralia	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Audrain County		d. STREET ADDRESS (If outside, give location) 304 East Barnes	
3. NAME OF DECEASED (Type or print) First Earl Middle Avory Last Grimes		4. DATE OF DEATH Month Dec Day 31 Year 1958	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 13, 1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Legal		10b. KIND OF BUSINESS OR INDUSTRY Lawyer	11. BIRTHPLACE (City and state or country) near Paris, Mo.
13a. FATHER'S NAME Leslie Alan Grimes		13b. MOTHER'S MAIDEN NAME Emily Harriett Whitesides	14. NAME OF HUSBAND OR WIFE Albina Grimes
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 487-05-9494A	17. INFORMANT Philip A. Grimes, Columbia, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral artery thromboses, multiple with encephalomalacia DUE TO (b) Cerebral arteriosclerosis DUE TO (c) Hypertensive cardio-vascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)			INTERVAL BETWEEN ONSET AND DEATH year year
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.) 443X	
20c. TIME OF INJURY Hour 5:30 Month, Day, Year 12-31-58 a.m. p.m.		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION Centralia COUNTY Boone STATE Missouri	
21. I attended the deceased from February 18, 1955 12-31-58 and last saw her/him alive on 12-30-58 Death occurred at approx. 5:30 p.m. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE John L. Ward MD (Degree or title)		22b. ADDRESS Centralia Mo	
22c. DATE SIGNED 1/2/59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Jan 2, 1959	23c. NAME OF CEMETERY OR CREMATORY Centralia	23d. LOCATION (City, town, or county) (State) Centralia, Mo.
24. FUNERAL DIRECTOR Bill G. Meador Centralia, Missouri ADDRESS		25. DATE REC'D. BY LOCAL REG. Jan 2-1959	26. REGISTRAR'S SIGNATURE Blanche Geely

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

JAN 27 1959

JAN 13 1959

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 Rep Miller

Licensed Embalmer No. 4492
P. O. Address Medico

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.