

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-001317

STATE FILE NUMBER

FILED JAN 21 1959

Registration District No. 149

Primary Registration District No. 1002

Registration No. 17

300  
-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Nebraska</b> b. COUNTY <b>Platte</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Columbus</b> <b>8260</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Luke's Hospital</b>		Length of stay in lb <b>5 Days</b>	d. STREET ADDRESS (If outside, give location) <b>R. R. # 4</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Bernice</b> Middle <b>Murl</b> Last <b>Grassman</b>			4. DATE OF DEATH Month <b>January</b> Day <b>2</b> Year <b>1959</b>		
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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>Aug. 22, 1909</b>	9. AGE In years (as birthday) <b>49</b>	F UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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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>Weeping Water, Nebraska</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
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13a. FATHER'S NAME <b>William Partridge</b>	13b. MOTHER'S MAIDEN NAME -----	14. NAME OF HUSBAND OR WIFE <b>Charles Grassman</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>507-20-4423</b>	17. INFORMANT <b>Charles Grassman</b>	Address <b>Columbus, Nebraska</b>
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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) <b>Sub-arachnoid hemorrhage</b> <b>fractured Brain</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input checked="" 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.) <b>Piding in a car when a sign on a passing truck struck windshield</b>
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20c. TIME OF INJURY Hour <b>12:27</b> Month, Day, Year <b>58</b> a.m. p.m.	20e. PLACE OF INJURY (e.g., in or about home, farm, city, street, office bldg., etc.) <b>Highway</b>	20f. CITY, TOWN, OR LOCATION <b>Highway 35 Cass</b>	COUNTY <b>019</b> STATE <b>MO</b>
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21. I attended the deceased from Death occurred at <b>6:40 A.</b> to _____, to _____ and last saw her alive on _____ m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>Hugh H. Owens</b> (Degree or title)	22b. ADDRESS <b>1034 Pacific Bldg</b>	22c. DATE SIGNED <b>1-2-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Jan. 2, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY -----	23d. LOCATION (City, town, or county) (State) <b>Columbus Nebraska</b>
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24. FUNERAL DIRECTOR <b>D.W. Newcomer's Sons</b>	ADDRESS <b>1331 Brush Creek Kansas City, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>1-4-59</b>	26. REGISTRAR'S SIGNATURE <b>neva minshall</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Hugh H. Owens

VS APR 25 1960

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 ..... *L. J. Nelson* .....

Licensed Embalmer No. *4421*

P. O. Address *Kearns* .....

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.