

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-001320

STATE FILE NUMBER

337

FILED FEB 5 1959 Registration District No. 149 Primary Registration District No. 1001 Registrar's No.

300
-57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Menorah Hospital		Length of stay in lb 20 years	d. STREET ADDRESS (If outside, give location) 5512 Park Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First GORDON Middle L. Last GROUT			4. DATE OF DEATH Month Jan. Day 17 Year 1959			
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 22, 1898	9. AGE (In years first birthday) 60	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Branch Mgr.	10b. KIND OF BUSINESS OR INDUSTRY First Bancredit Corp.	11. BIRTHPLACE (City and state or country) George, Iowa	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME LeRoy Grout	13b. MOTHER'S MAIDEN NAME Luena Boyd	14. NAME OF HUSBAND OR WIFE Fidelia Grout
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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) No	16. SOCIAL SECURITY NO. 477-05-8917	17. INFORMANT John Grout	Address 8833 Wayne
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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) PULMONARY EDEMA		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Left VENTRICULAR Hypertrophy	
	DUE TO (c) HYPERTENSIVE Cardiovascular Disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) U.S.A.		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.)
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20c. TIME OF INJURY Hour 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 St. Paul, Minnesota	COUNTY H.C.Mo.	STATE
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21. I attended the deceased from 1-3-59 to 1-17-59 and last saw her/him alive on 1-16-59 Death occurred at 2:50 AM m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) David Waxman M.D.	22b. ADDRESS 4840 Project	22c. DATE SIGNED 1-17-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE Jan. 19, 1959	23c. NAME OF CEMETERY OR CREMATORY Acacia Park Cemetery	23d. LOCATION (City, town, or county) (State) St. Paul, Minnesota H.C.Mo.
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24. FUNERAL DIRECTOR FREEMAN MORTUARY	ADDRESS Kansas City, Mo.	25. DATE RECD. BY LOCAL REG. 1-19-59	26. REGISTRAR'S SIGNATURE neve minshall
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David Waxman
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION
 All diseases in Part I must be causally related.

484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500
ON 1-1-1911
A. C. M.

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 *Walter H. Erwin*

Licensed Embalmer No. *4352*

P. O. Address *H. C. Mo.*

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.