

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-005143

STATE FILE NUMBER

FILED MAR 2 1959

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 188

300
1-57

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Polk	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		c. CITY OR TOWN Bolivar	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Baptist Hospital		d. STREET ADDRESS (If outside, give location) 1 1/2 hrs	
3. NAME OF DECEASED (Type or print) First ETHEL Middle GRABLE Last GRABLE		4. DATE OF DEATH Month February Day 21 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 8, 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life) Housewife (Cafeteria Cook & Server)		10b. KIND OF BUSINESS OR INDUSTRY Home (School)	11. BIRTHPLACE (City and state or country) Polk County, Missouri
13a. FATHER'S NAME W. B. Erwin		13b. MOTHER'S MAIDEN NAME Ayres	14. NAME OF HUSBAND OR WIFE ---
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. 495-20-9382	17. INFORMANT Frank Grable, Mtn. Grove, Missouri
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive cerebral artery hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 5 hours	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 33ix	
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 _____ a.m. _____ p.m. Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT 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 Springfield, Mo.	
21. I attended the deceased from 21 Feb 11 59 , to 21 Feb 1959 and last saw him/her alive on 21 Feb 1959 Death occurred at 2:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.		22c. DATE SIGNED 23 Feb 1959	
22a. SIGNATURE Francis M. Maple MD		22b. ADDRESS Springfield, Mo.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb 24, 1959	
23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		23d. LOCATION (City, town, or county) (State) Bolivar, Missouri	
FUNERAL DIRECTOR Jewell E. Windle		25. DATE RECD. BY LOCAL REG. 2-24-59	
ADDRESS Springfield, Mo.		26. REGISTRAR'S SIGNATURE Effie E. Melton	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Color, contour, etc. must use only standard nomenclature of item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Robert E. Muhleman*

Licensed Embalmer No. *4916*

P. O. Address *Springfield*

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.