

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024236

FILED VS JUL 20 1959

Registration District No. 2 Primary Registration District No. 1000 Registrar's No. 712

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b Over 50 Yrs	c. CITY OR TOWN St. Joseph Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Hillside Rest Home 718 North 7th		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 605 Francis St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) WILLIAM MC GRAIL			4. DATE OF DEATH July 12, 1959	
First	Middle	Last	Month	Day

5. SEX Male	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 10-7-1873	9. AGE (last birthday) 85	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
-----------------------	----------------------------------	---	--------------------------------------	-------------------------------------	---	----------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Ret. (10) Retail Store Owner & Bank President	10b. KIND OF BUSINESS OR INDUSTRY Brookfield, Mo.	11. BIRTHPLACE (City and state or country) USA	12. CITIZEN OF WHAT COUNTRY USA
--	---	--	---

13a. FATHER'S NAME Michael Mc Grail	13b. MOTHER'S MAIDEN NAME Margaret Duffy	14. NAME OF HUSBAND OR WIFE Caroline McGrail
---	--	--

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. 488-14-2613	17. INFORMANT Myron Coots	Address St. Joseph, 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) Rheumatic Heart, & Mitral Damage - Hypertrophy & failure Atherosclerotic general		INTERVAL BETWEEN ONSET AND DEATH ?
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)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
---	--

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.)
---	---	--

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	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
---	--	--	---

21. I attended the deceased from Oct 19, 1948 to July 12, 1959 and last saw ^{her} him alive on 6-11-59 Death occurred at 5:30 P on the date stated above, and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) Wm B. Rosten	22b. ADDRESS 316 N. 10th St Joseph Mo	22c. DATE SIGNED 7-13-59
---	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE July 15, 1959	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph, Mo.
--	-----------------------------------	--	---

24. FUNERAL DIRECTOR H.O. Sidenfaden & Son	ADDRESS St Joseph, Mo	25. DATE RECD. BY LOCAL REG. July 14, 1959	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell
--	---------------------------------	--	--

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT MEDICAL CERTIFICATION W.B. ROST, M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Robert H. Yaph

Licensed Embalmer No. 3308

P. O. Address St. Joseph, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.