

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031640

FILED VS OCT 5 1959 43

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 436

STATE FILE NUMBER

DED

| | | | | | | | | |
|---|---|---|--|--|--|--|---|-------|
| 1. PLACE OF DEATH a. COUNTY Butler | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Iron | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Poplar Bluff, Cane Creek Twnsp. | | Length of stay in 1b | | c. CITY OR TOWN Arcadia | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION His Farm, Cane Creek Twnsp. | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) None | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Roy F. LeGrand | | | | 4. DATE OF DEATH Month Day Year Sept. 8, 1959 | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH Jan. 13, 1895 | 9. AGE (last birthday) 64 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) Butler County, Mo. U.S. | | 12. CITIZEN OF WHAT COUNTRY | |
| 13a. FATHER'S NAME Ruben L. LeGrand | | | 13b. MOTHER'S MAIDEN NAME Sarah King | | | 14. NAME OF HUSBAND OR WIFE Clara Thomas LeGrand | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 1 | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Mrs. R.F. LeGrand, Arcadia, 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) Coronary Thrombosis DUE TO (b) Arterial sclerosis, general DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH short 10 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Has had several attacks myocardial infarct | | | | | | 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 a.m. p.m. Month, Day, Year | | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 7-15-50 to 9-8-59 and last saw him alive on 3-21-59 Death occurred at 3:00 P. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Degree or title) Ben M. Bull, M.D. | | | | 22b. ADDRESS Ironton, Mo. | | | 22c. DATE SIGNED 9-14-59 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 9-10-59 | 23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cem. | | 23d. LOCATION (City, town, or county) (State) St. Louis, Mo. | | | |
| 24. FUNERAL DIRECTOR Frank Cotrell Poplar Bluff, Mo. | | | | 25. DATE RECD. BY LOCAL REG. 9/21/59 | | 26. REGISTRAR'S SIGNATURE [Signature] | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

OCT 5 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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Edgar W. Taylor

Licensed Embalmer No. 3394

P. O. Address Poplar Bluff

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.