RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS OCT 5 1959

59–031998
STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1010

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY: Greene
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Springfield
Length of stay in 1b:
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St. Johns Hospital
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Greene
c. CITY OR TOWN: Springfield
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 2018 N. Park
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: TILMAN Middle: H. Last: GRANTHAM
4. DATE OF DEATH: Month: September Day: 25, Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 27 July 1881
9. AGE (last birthday): 78
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): City Bus Driver Operator
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (City and state or country): Missouri
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Unknown
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: May Grantham
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Hospital Records Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Arteri-Sclerosis
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 30 min
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 8-30-59, to 9/25/59 and last saw him alive on 9-25-59
Death occurred at 12:50 P.m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: [illegible] M.D. (Degree or title)
22b. ADDRESS: Spgfd. Medical Bldg. Springfield, Missouri
22c. DATE SIGNED: 9-26-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 9/28/59
23c. NAME OF CEMETERY OR CREMATORY: Greenlawn
23d. LOCATION (City, town, or county) (State): Springfield, Mo.

24. FUNERAL DIRECTOR: KLINGNER MORTUARY, INC. ADDRESS: Springfield, Mo.
25. DATE RECD. BY LOCAL REG.: 9-30-59
26. REGISTRAR'S SIGNATURE: Effie G. Meeton

JHC

(Licensed Embalmer's Statement on Reverse Side)

OCT 6 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 _____

Licensed Embalmer No. 407

P. O. Address _____

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