

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-037322

FILED VS. OCT 27 1959 316

Primary Registration District No. 3059 Registrar's No. 411

STATE FILE NUMBER

RENDERED

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St Francois</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before<br>a. STATE <b>Mo</b> b. COUNTY <b>St Francois</b> (mission) |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Bonne Terre</b>                 |  | Length of stay in 1b<br><b>**</b>   | c. CITY OR TOWN <b>Bonne Terre.</b> Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                            |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Bonne Terre Hosp.</b> |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>Rt 2:</b> Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|--|--|--|-------------------------------------|--|--|--|
| 3. NAME OF DECEASED (Type or print) <b>* WILLIAM GRAYSON *</b> |  |  | 4. DATE OF DEATH <b>Oct 21 1959</b> |  |  |  |
| First Middle Last  |  |  | Month Day Year                      |  |  |  |

|                     |                               |   |                                   |                                  |   |                              |
|---------------------|-------------------------------|---|-----------------------------------|----------------------------------|---|------------------------------|
| 5. SEX <b>Male:</b> | 6. COLOR OR RACE <b>White</b> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <b>12 7 1880</b> | 9. AGE (last birthday) <b>78</b> | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HR<br>Hours Min. |
|---------------------|-------------------------------|---|-----------------------------------|----------------------------------|---|------------------------------|

|   |   |   |   |
|---|---|---|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Unknown</b> | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>***</b> | 11. BIRTHPLACE (City and state or country)<br><b>St. Francois Co.</b> | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b> |
|---|---|---|---|

|  |  |  |
|--|--|--|
| 13a. FATHER'S NAME<br><b>William Grayson</b> | 13b. MOTHER'S MAIDEN NAME<br><b>Mary Leftridge</b> | 14. NAME OF HUSBAND OR WIFE<br><b>Olive E. Ware:</b> |
|--|--|--|

|   |                                       |  |
|---|---------------------------------------|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b> | 16. SOCIAL SECURITY NO.<br><b>***</b> | 17. INFORMANT Address<br><b>Lester B. Moss St Louis, Mo.</b> |
|---|---------------------------------------|--|

|  |                                |                                  |
|--|--------------------------------|----------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> |                                | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.   | DUE TO (b) <b>Hypertension</b> |                                  |
|  | DUE TO (c)                     |                                  |

|   |  |
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| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
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|--|---|--|
| 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 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 **Aug 1 - 1959** to **Oct 17 - 1959** and last saw her/him alive on **Oct 17 - 1959**  
 Death occurred at **10:00** p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

|   |                                    |                                  |
|---|------------------------------------|----------------------------------|
| 22a. SIGNATURE <b>[Signature]</b> (Degree or title) <b>J.O.</b> | 22b. ADDRESS <b>Bonne Terre Mo</b> | 22c. DATE SIGNED <b>10-22-59</b> |
|---|------------------------------------|----------------------------------|

|   |                                |   |   |
|---|--------------------------------|---|---|
| 23a. BURIAL / CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 23b. DATE<br><b>10:24 1959</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sandy Baptist Cem.</b> | 23d. LOCATION (city, town, or county) (State)<br><b>Jefferson County, Mo.</b> |
|---|--------------------------------|---|---|

|  |  |   |
|--|--|---|
| 24. FUNERAL DIRECTOR ADDRESS<br><b>C Z Boyer &amp; Son Inc.. Bonne Terre</b> | 25. DATE RECD. BY LOCAL REG.<br><b>Oct. 23, 1959</b> | 26. REGISTRAR'S SIGNATURE<br><b>[Signature]</b> |
|--|--|---|

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

~~6961-0-100 SA~~

6961 0-3 100 SA

**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 B. T. Boyer  
B. T. Boyer

Licensed Embalmer No. 366  
P. O. Address Desloge, 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.