

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-040902

FILED VS. NOV 18 1959

187

Primary Registration District No. 3040

Registrar's No. 264

STATE FILE NUMBER

MEMBERED

1. PLACE OF DEATH a. COUNTY LIVINGSTON				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY CALDWELL			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CHILLICOTHE		Length of stay in lb 20 MONTHS		c. CITY OR TOWN BRECKENRIDGE		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION SUSAN'S NURSING HOME		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) NONE			
3. NAME OF DECEASED (Type or print) BESSIE BELL GROZINGER				4. DATE OF DEATH Month NOV Day 9 Year 1959			
5. SEX FEMALE	6. COLOR OR RACE CAUC	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/19/1891	9. AGE (last birthday) 68 YEARS	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) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		11. BIRTHPLACE (City and state or country) MISSOURI		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME TOM MERRIOTT		13b. MOTHER'S MAIDEN NAME EMILY ALEXANDER		14. NAME OF HUSBAND OR WIFE GEORGE E. GROZINGER			
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. NONE		17. INFORMANT NEVA E THOMPSON Address Chillicothe 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) Chronic Leukemia						INTERVAL BETWEEN ONSET AND DEATH over 5 years	
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) Fracture of right hip - that failed to heal				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 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.) Automa			
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 July 1956 , to Nov. 9, 1959 and last saw her alive on Nov 6, 1959 Death occurred at 10:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE William L. Fair, M.D. (Degree or title)				22b. ADDRESS Chillicothe, Mo		22c. DATE SIGNED 11/12/59	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE NOV 11, 1959		23c. NAME OF CEMETERY OR CREMATORY BLUE MOUND CEM		23d. LOCATION (City, town, or county) BLUE MOUND Mo.	
24. FUNERAL DIRECTOR Mead-Pitts Funeral Services ADDRESS BRECKENRIDGE Mo.		25. DATE RECD. BY LOCAL REG. 11/12/59		26. REGISTRAR'S SIGNATURE Francisco B Reed			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 8 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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John W. Pitte

Licensed Embalmer No. 5074

P. O. Address _____

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.