

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-002466

FILED VS JAN 29 1960 200 Registration District No. 3041 Primary Registration District No. 16 Registrar's No. 16

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Macon</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Macon</u> Length of stay in 1b <u>-</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>-</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Macon</u> c. CITY OR TOWN <u>Macon</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>603 Pearl</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA E. GRABLE</u>			4. DATE OF DEATH Month Day Year <u>1 - 23 - 60</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>7-20-96</u>	9. AGE (last birthday) <u>63</u>	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) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (City and state or country) <u>Macon Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Geo. B. Grable</u>			13b. MOTHER'S MAIDEN NAME <u>Margaret Smith</u>		14. NAME OF HUSBAND OR WIFE <u>-</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>498-30-9444</u>		17. INFORMANT Address <u>Elsie Oldaker, Florida</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dependence</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Drinking Alcohol 13 55 days before death</u> DUE TO (c) <u>-</u> 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 checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>-</u>			
20c. TIME OF INJURY Hour Month, Day, Year <u>11:50am 1/23/60</u>		20d. PLACE OF INJURY (e.g., in or about home, factory, street, office bldg., etc.) <u>at home</u>		20e. CITY, TOWN, OR LOCATION COUNTY STATE <u>Macon</u> <u>Macon</u> <u>Missouri</u>			
21. I attended the deceased from <u>1950</u> and last saw her/him alive on <u>1/23/60 at 3:30 pm</u> Death occurred at <u>3:30 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Clayton Carroll D.O.</u>			22b. ADDRESS <u>Macon Missouri</u>		22c. DATE SIGNED <u>1/25/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1-25-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wm. Fin. Cem.</u>			
23d. LOCATION (City, town, or county) (State) <u>Macon</u> <u>Mo</u>		24. FUNERAL DIRECTOR ADDRESS <u>805 Edward Avenue Mo</u>		25. DATE RECD. BY LOCAL REG. <u>1/26/60</u>			
26. REGISTRAR'S SIGNATURE <u>Clayton Carroll</u>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FEB 19 1960

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 W. Edwards

Licensed Embalmer No. 1961

P. O. Address Edwards, MD

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.