

JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-021989

FILED VS

JUN 13 1960

STATE FILE NUMBER

Registration District No. 324 Primary Registration District No. 6093 Registrar's No. 120

1. PLACE OF DEATH a. COUNTY <b>Saline</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Osage</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Marshall</b>		c. CITY OR TOWN <b>Freeburg</b>	
Length of stay in 1b <b>18 yrs.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <b>Marshall State School &amp; Hosp., Marshall, Mo.</b>		d. STREET ADDRESS (If outside, give location) <b>-----</b>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Loretta</b> Middle <b>Barbara</b> Last <b>Gradel</b>			4. DATE OF DEATH Month <b>June</b> Day <b>8</b> Year <b>1960</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8-18-1931</b>	9. AGE (last birthday) <b>28</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Patient</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	11. BIRTHPLACE (City and state or country) <b>Freeburg, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U S A</b>
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13a. FATHER'S NAME <b>Anton Gradel</b>	13b. MOTHER'S MAIDEN NAME <b>Odellia Holder</b>	14. NAME OF HUSBAND OR WIFE <b>-----</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Records <b>Marshall State School &amp; Hosp.</b>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b>		
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) <b>Congenitally spastic, mentally retarded, idiot level</b>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" 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.)
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 **April 1, 1958** to **June 8, 1960** and last saw <sup>her</sup> <sub>him</sub> alive on **June 8, 1960**  
Death occurred at **5:50 p.m.** \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>A. B. Day M. D.</b>	(Degree or title) <b>M. D.</b>	22b. ADDRESS <b>Marshall State School &amp; Hosp., Marshall, Mo.</b>	22c. DATE SIGNED <b>6-8-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>6-11-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Holy Family Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Freeburg</b>
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24. FUNERAL DIRECTOR <b>Harry Herschberger</b>	ADDRESS <b>Marshall Mo</b>	25. DATE RECD. BY LOCAL REG. <b>6-8-'60</b>	26. REGISTRAR'S SIGNATURE <b>Cecil G. Reed</b>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Harry Hershberger

Licensed Embalmer No. 435

P. O. Address Marshall

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.