

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048947  
STATE FILE NUMBER

DED

Registration District No. 685 Primary Registration District No. \_\_\_\_\_ Registrar's No. 18-61

**FILED VS FEB 21 1961**

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <b>McDonald</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Anderson</b>		a. STATE <b>Missouri</b>		b. COUNTY <b>McDonald</b>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Route 1 Anderson</b>		Length of stay in 1b <b>40 years</b>		c. CITY OR TOWN <b>Anderson</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>Route 1 Anderson</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <b>ELVA</b>		Middle <b>MYRTLE</b>		Last <b>GRIFE</b>		Month Day Year <b>Dec. 19 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4-18-1876</b>	9. AGE (last birthday) <b>84</b>	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) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Homemaking</b>		11. BIRTHPLACE (City and state or country) <b>Barnes City, Iowa</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Myron Archa Brigham</b>			13b. MOTHER'S MAIDEN NAME <b>Martha Maria Barnes</b>			14. NAME OF HUSBAND OR WIFE <b>Frank R. Grife</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 Address <b>Alvie Grife Anderson, Mo.</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	
IMMEDIATE CAUSE (a) <b>Cerebral anoxia</b>						one week	
DUE TO (b) <b>Respiratory Paralysis</b>							
DUE TO (c) <b>Cerebral Hemorrhage</b>							
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"/> N- <input type="checkbox"/> Unknown	
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 <b>December 12 1960</b> to <b>12-12-1960</b> and last saw her/him alive on <b>December 12 1960</b> Death occurred at <b>6:55 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>A. J. Bush D.D.</i> (Degree or title)				22b. ADDRESS <b>Anderson Missouri</b>		22c. DATE SIGNED <b>12-23-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Dec. 22, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Banner</b>		23d. LOCATION (City, town, or county) (State) <b>McDonald County, Mo.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Roller Funeral Home Goodman, Mo</b>				25. DATE RECD. BY LOCAL REG. <b>February 17, 1961</b>		26. REGISTRAR'S SIGNATURE <i>Mary A. Bradley</i>	

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 \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Robert C. Keller

Licensed Embalmer No. 506

P. O. Address Anderson

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.