

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-015006

STATE FILE NUMBER

Registration District No. 740 Primary Registration District No. 3024 Registrar's No. 28

FILED MAY 15 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

10451

20451

3

4 1

5 1

6

7 0

8 2

9241X

10

11

121-0

131-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY Howard		a. STATE Missouri COUNTY Howard	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fayette		c. CITY OR TOWN Fayette	
Length of stay in lb 45 days		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lee Hospital		d. STREET ADDRESS (If outside, give location) 401 West Morrison	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First MABEL Middle INA Last GRAPES		Month MAY Day 6 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/24/92
9. AGE (last birthday) 69		IF UNDER 1 YEAR Months Days Hours Min.	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 Own Home	11. BIRTHPLACE (City and state or country) Howard Co. Missouri
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Jerry T. Golden	
13b. MOTHER'S MAIDEN NAME Nancy E. Warford		14. NAME OF HUSBAND OR WIFE Grover C. Grapes	
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 Mr Grover C. Grapes Fayette, Mo
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:		1 month	
IMMEDIATE CAUSE (a) Cardiac decompensation			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		1 yr.	
DUE TO (b) Asthma - severe -			
DUE TO (c)			
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 checked="" 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 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 1961 to 3-6-62 and last saw her/him alive on 5-6-62		Death occurred at 5 A m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE M. P. Leach M.D. (Degree or title)		22b. ADDRESS Fayette, Mo	22c. DATE SIGNED 5/1/62 (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5/8/62	23c. NAME OF CEMETERY OR CREMATORY New Hope Cemetery	23d. LOCATION (City, town, or county) Howard Co. Missouri
24. FUNERAL DIRECTOR Ralph A. Carr ADDRESS Fayette, Mo		25. DATE RECD. BY LOCAL REG. 5-7-62	26. REGISTRAR'S SIGNATURE Katherine Welch

Permit issued 5-7-62

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 Ralph A. Carr

Licensed Embalmer No. 3340

P. O. Address Fayette, 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.