

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**63-037807**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

1003

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. \_\_\_\_\_ Registrar's No. 9281

FILED SEP 19 1963

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Dent</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b		c. CITY OR TOWN <b>Salem</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Deaconess Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>West 6th St.</b>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>F.</b> Last <b>McGrath</b>			4. DATE OF DEATH Month <b>September</b> Day <b>14</b> Year <b>1963</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	
8. DATE OF BIRTH <b>4/11/1893</b>		9. AGE (last birthday) <b>70</b>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self Employed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retail Dairyman</b>		11. BIRTHPLACE (City and state or country) <b>Lyons, Kansas</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>		13a. FATHER'S NAME <b>Thomas McGrath</b>		13b. MOTHER'S MAIDEN NAME <b>Susie Clark</b>	
14. NAME OF HUSBAND OR WIFE <b>Gladys</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>Unknown</b>	
17. INFORMANT <b>Gladys McGrath, Salem, Mo.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>Arteriosclerotic heart disease</b>			
		DUE TO (c) <b>4200</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arteriolar nephrosclerosis</b>				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 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 checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <b>Salem, Mo.</b>	
21. I attended the deceased from <b>8-29-63</b> to <b>9-14-63</b> and last saw her/him alive on <b>9-14-63</b>		Death occurred at <b>5:00 pm</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22. SIGNATURE <i>C. E. Muller</i>		(Degree or title) <b>M.D.</b>		22b. ADDRESS <b>634 N. Grand Blvd.</b>	
22c. DATE SIGNED <b>9-16-63</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>9-17-63</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Grove Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Salem, Mo.</b>			
24. FUNERAL DIRECTOR <b>Warfel Funeral Home, Salem, Mo.</b>		ADDRESS		25. DATE RECD. BY LOCAL REG. <b>SEP 16 1963</b>	
				26. REGISTRAR'S SIGNATURE <i>W. Smith, M.D.</i>	

OCT 8 1963

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 Harvey Kable

Licensed Embalmer No. 4596

P. O. Address St Louis, 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.

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

163-037807

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9281** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		e. STATE <b>Missouri</b> b. COUNTY <b>Dent</b>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Deaconess Hospital</b>		d. STREET ADDRESS (if outside, give location) <b>West 6th St.</b>	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First Middle Last <b>William F. McGrath</b>			Month Day Year <b>September 14, 1963</b>		
5. SEX	6. COLOR OR RACE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR IF UNDER 24 HR.
<b>Male</b>	<b>White</b>		<b>4/11/1893</b>	<b>70</b>	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)	
<b>Self Employed</b>		<b>Retail Dairyman</b>		<b>Iowa</b>	
12a. FATHER'S NAME		12b. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY	
<b>Thomas McGrath</b>		<b>Susie Clark</b>		<b>U.S.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT
<b>No</b>			<b>Unknown</b>		<b>Gladys McGrath, Salem, 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 <b>24 hrs.</b>
IMMEDIATE CAUSE (a) <b>Myocardial infarction</b>		
DUE TO (b) <b>Arteriosclerotic heart disease</b>		
DUE TO (c) <b>4200</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.
<b>Arteriolar nephrosclerosis</b>		<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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from <b>8-29-63</b> to <b>9-14-63</b> and last saw her/him alive on <b>9-14-63</b>		Death occurred at <b>5:00 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.	

22. SIGNATURE (Degree or title) <i>C. E. Mueller</i> M.D.		22b. ADDRESS <b>634 N. Grand Blvd.</b>		22c. DATE SIGNED <b>9-16-63</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
<b>Removed</b>		<b>9-17-63</b>		<b>Cedar Grove Cemetery</b>	
24. FUNERAL DIRECTOR		ADDRESS		25. DATE RECD. BY LOCAL REG.	
<b>Warfel Funeral Home, Salem, Mo.</b>				<b>SEP 16 1963</b>	
				26. REGISTRAR'S SIGNATURE <i>Neal Smith, M.D.</i>	

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 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 LYONS, Kansas  
 LYONS, Iowa  
 DOCUMENT Iowa Birth Cert #23-93-35  
 BY AFFIDAVIT OF Next of Kin  
 MEDICAL CERTIFICATION  
 ITEM NO. SHOULD READ  
 11 LYONS, Iowa

USE BLACK INK OR TYPEWRITER RIBBON

