

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

65-031643

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUD

AMENDED

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 197

FILED AUG 30 1965

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| VS 300 Rev. 4/59 | DATE AMENDED | AMENDMENTS ON THIS RECORD ARE AS FOLLOWS | ITEM NO. | SHOULD READ | BY AFFIDAVIT OF |
| 1 0425 | | | | | |
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| 1. PLACE OF DEATH a. COUNTY Henry | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Henry | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clinton, Mo. | | c. CITY OR TOWN Windsor, | |
| Length of stay in 1b 3 days | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Wetzel Hospital | | d. STREET ADDRESS 200 S. Commercial (If outside, give location) | |
| 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) Pearl May Grose | | 4. DATE OF DEATH August 23, 1965 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 12/12/1893 |
| 9. AGE (last birthday) 71 | | 10. IF UNDER 1 YEAR Months Days 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 | |
| 11. BIRTHPLACE (City and state or country) Carroll County, Mo. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME James D. Cave | | 13b. MOTHER'S MAIDEN NAME Martha Ellen Anderson | |
| 14. NAME OF HUSBAND OR WIFE Earnest Fredrick Grose | | | |
| 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 Lowell Cave, Edinburg, Texas | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Medullary Abscess</i> <i>Ant. Central Venous Thrombosis</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Complete</i> DUE TO (c) <i>Cerebral arteriosclerosis</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>months</i> <i>4 1/2 yrs.</i> <i>Year.</i> | |
| 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 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 8/18/65 to 8/23/65 and last saw her alive on 8/23/65. Death occurred at 9:45 AM 8/23/65 m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22. SIGNATURE (Degree or title) <i>James C. Clouse DO</i> | | 22b. ADDRESS 105 E. Ohio Pleasanton, Mo. | |
| 22c. DATE SIGNED 8/23/65 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 8/25/1965 | 23c. NAME OF CEMETERY OR CREMATORY Ionia Cemetery | |
| 23d. LOCATION (City, town, or county) Ionia, Missouri | | | |
| 24. FUNERAL DIRECTOR Clifford Gouge Windsor, Mo. | | 25. DATE RECD. BY LOCAL REG. 8-25-65 | |
| 26. REGISTRAR'S SIGNATURE Mildred Bigum | | | |

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 Clifford Gouge

Licensed Embalmer No. 5014

P. O. Address Windsor, 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.