

FILLED JUN 16 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 17931

Registration District No. 347 Primary Registration District No. 3018 Registrar's No.

1. PLACE OF DEATH:
(a) County Henry
(b) City or town Clinton Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Community Clinic
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 1/2 (Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Mildred Grabeal
3. (b) If veteran, NO name war
3. (c) Social Security No. NO

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years

7. Birth date of deceased: Feb 29 1928
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
13 2 2 hr. min.

9. Birthplace Griggs Oklahoma
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business _____
MOTHER FATHER { 12. Name Elmer Grabeal
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name Jessie Grabeal
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Guy Wilson
(b) Address Brownington, Mo

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) 5-26-41 (b) Dr. J. R. Hampton
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County 42
(c) City or town _____ (If outside city or town limits, write "RURAL") 0
(d) Street No. _____ (If rural, give location) 0
(e) If foreign born, how long in U. S. A? 0 years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 5 day 1
year 1941 hour 3 minute 45 p. M.
21. I hereby certify that I attended the deceased from 5-1-41
19____ to 5-141 19____;
that I last saw her alive on 5-1 1941
and that death occurred on the date and hour stated above.

Immediate cause of death: Acute Cardiac Distention
Due to Acute Asthmatic Attack
Due to Chronic Asthma 6 yrs.
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: 117
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place) Means of injury _____
23. Signature Eugene S. Nail (M. D. or other) MD
Address Clinton Mo Date signed 5-2-41

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 7

District File Number 6-4-1038

Date Filed 6-13-41

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed

G. W. Smith

Licensed Embalmer No. 2782

P. O. Address Deepwater, 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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 347

Primary Registration District No. 3018

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Henry
(b) City or town Clinton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Comm. Clinic, Henry Co.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 hours
(Specify whether years, months or days)
In this community 3 weeks

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Henry
(c) City or town Brownsville, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mildred Grabesh
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year
7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 13 Months 2 Days 2 If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) J. R. Humphreys
(Date received local registrar) (Registrar's Signature)

DEATH CERTIFICATION

20. DATE OF DEATH: Month 5 day 1
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
that I last saw h. _____ alive on _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____ (e) Means of injury _____

23. Signature Eugene D. Neville (M.D. or other) _____
Address Clinton Mo Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

S-17931