

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=63-019850

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 137 Primary Registration District No. 5507 Registrar's No. 154

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 0420
2 0420
3
4 0
5 1
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7 1
8 2
9 4200
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12 90-0
13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED MAY 20 1963	
1. PLACE OF DEATH a. COUNTY <u>Henry</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Ladue</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Ladue</u>	
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Henry</u>	
c. CITY OR TOWN <u>Ladue</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS <u>Ladue</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROBERT C</u> Middle <u>GRIGSBY</u> Last <u>GRIGSBY</u>	
4. DATE OF DEATH <u>May 14 1963</u> Month <u>May</u> Day <u>14</u> Year <u>1963</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>
7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 24 1868</u>
9. AGE (last birthday) <u>94</u> Months <u>5</u> Days <u>20</u> Hours <u></u> Min. <u></u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>
11. BIRTHPLACE (City and state or country) <u>Ohio</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Alfred Grigsby</u>	13b. MOTHER'S MAIDEN NAME <u>Sarah White</u>
14. NAME OF HUSBAND OR WIFE <u>Nanner Grigsby</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, except unknown) (If yes, give war or dates of service) <u>No</u>
16. SOCIAL SECURITY NO. <u>No</u>	17. INFORMANT <u>Cecil Grigsby</u> Address <u>K.C. Mo</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic heart disease</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>None</u>	
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 <u>4/2/63</u> to <u>5/14/63</u> and last saw ^{her} him alive on <u>5/12/63</u> Death occurred at <u>7:30 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>S. B. Hughes M.D.</u>	22b. ADDRESS <u>Clinton, Mo.</u>
22c. DATE SIGNED <u>5/15/63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>5-17-63</u>
23c. NAME OF CEMETERY OR CREMATORY <u>Bear Creek</u>	23d. LOCATION (City, town, or county) (State) <u>Henry Co. Mo.</u>
24. FUNERAL DIRECTOR <u>F. L. SCHABERS</u> ADDRESS <u>Cleveland Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>5-17-63</u>
26. REGISTRAR'S SIGNATURE <u>Mildred Bigum</u>	

USE BLACK INK OR TYPEWRITER RIBBON

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 F. L. Schobert

Licensed Embalmer No. 4513

P. O. Address Oletha, Md

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.

Permit Obtained 5-19-63 (MBA)