

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

67 0031880

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 206 Primary Registration District No. 3042 Registrar's No. 625 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 6 1967

VS 300
Rev. 4/59

1 0621

2 0940

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Madison		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY St. Francois	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fredericktown		Length of stay in 1b 2 Wks.	c. CITY OR TOWN Elvins Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Madison Co. Memorial		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 519 W. Main St. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Gilbert (NMI) De Grant			4. DATE OF DEATH Month Day Year Aug 28, 1967
5. SEX Male	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 5/9/1899
9. AGE (last birthday) 68		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) Retired Mine Supply		10b. KIND OF BUSINESS OR INDUSTRY St. Joseph Lead	11. BIRTHPLACE (City and state or country) Doe Run, Missouri
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME William De Grant	
13b. MOTHER'S MAIDEN NAME Artie M. Crunkelton		14. NAME OF HUSBAND OR WIFE Blanche De Grant	
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. 493-03-9077	17. INFORMANT Robert De Grant Flat River, Mo
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Ht. dis			INTERVAL BETWEEN ONSET AND DEATH 10 yrs
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) Diabetes & asthma			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 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 10:57 to Aug 28, 1967 and last saw him alive on Aug 28, 1967 Death occurred at 10:15 PM m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE R. G. Duckert MD (Degree or title)		22b. ADDRESS Farmington, Missouri	22c. DATE SIGNED 8/30/67
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 8/28/1967	23c. NAME OF CEMETERY OR CREMATORY St. Francois Memo	23d. LOCATION (City, town, or county) (State) Bonne Terre, Mo Rt. #2
24. FUNERAL DIRECTOR Murphy L. Sparks Flat River, Mo ADDRESS		25. DATE RECD. BY LOCAL REG. 8-31-67	26. REGISTRAR'S SIGNATURE D. E. Seltensick Reg. Secy

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 Murphy Sparks

Licensed Embalmer No. 4256

P. O. Address Flint Hill Ave

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.