

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **40614**

FILED DEC 20 1954

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **1101-A**

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Texas</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Springfield</b>		c. LENGTH OF STAY (in this place) c. CITY OR TOWN <b>Cabool</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Johns Hospital</b>		e. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>PAUL</b>	b. (Middle) <b>SILAS</b>	c. (Last) <b>GRANT</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Dec. 2, 1954</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>May 17, 1887</b>	9. AGE (In years last birthday) <b>67</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lumberman</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Lumber</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Cabool, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
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13a. FATHER'S NAME <b>Silas Wright Grant</b>	13b. MOTHER'S MAIDEN NAME <b>Margaret</b>	14. NAME OF HUSBAND OR WIFE <b>Mildred Grant</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes World War I</b>	16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Mildred Grant</b>	ADDRESS <b>Cabool, Mo.,</b>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Thrombosis middle meningeal artery, left.</b>		
	ANTECEDENT CAUSES <b>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</b>		
DUE TO (b) <b>Cerebral arteriosclerosis</b>		DUE TO (c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>334 X</b>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>Springfield, Greene, Mo.</b>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Nov 30, 1954**, to **Dec 2, 1954**, that I last saw the deceased alive on **Dec 2, 1954** and that death occurred at **3:45 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>D. D. Wilkey M. D.</b>	23b. ADDRESS <b>Springfield, Missouri</b>	23c. DATE SIGNED <b>12/3/1954</b>
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24a. BURIAL CREMATION REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>12/3/1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>C - - - - - Cabool</b>	24d. LOCATION (City, town, or county) (State) <b>Missouri</b>
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DATE REC'D BY LOCAL REG. <b>12-14-54</b>	REGISTRAR'S SIGNATURE <b>Robert Williamson</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Harry C. ...</b>	ADDRESS <b>Springfield, Mo.,</b>
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING INK—MISSOURI A PERMANENT RECORD

DEC 31 1955

FEB 3 1955

**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.....  
*Harry [Signature]*  
Licensed Embalmer No. 4519

P. O. Address Springfield

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.