

MAY 31 1928

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

12770

1. PLACE OF DEATH

County DeKalb Registration District No. 258 File No. _____
Township Washington Primary Registration District No. 6360A Registered No. _____
City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Eligah Moore Groom
(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. 5 mos. 7 da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED OR DIVORCED HUSBAND OF (OR) Wife of John Groom

6. DATE OF BIRTH (MONTH, DAY AND YEAR) February 2, 1858

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
70 2 26

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Heat Springs
(STATE OR COUNTRY) Missouri (Calumet)

10. NAME OF FATHER James Groom

11. BIRTHPLACE OF FATHER (CITY OR TOWN) East Hill
(STATE OR COUNTRY) Kentucky

12. MAIDEN NAME OF MOTHER Rebecca Adams

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Owens
(STATE OR COUNTRY) Kentucky

14. INFORMANT Harley Groom
(Address) Clarksdale, Mo.

15. FILED Apr 25, 1928 C. M. Davis
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/28/28 1928

17. I HEREBY CERTIFY, That I attended deceased from 4/25/28, 1928, to 4/27/28, 1928, that I last saw him alive on Apr. 27/28, 1928, and that death occurred, on the date stated above, at 3.36 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonitis

CONTRIBUTORY Duodinal Ulcer and
(SECONDARY) several yrs.
Mitral Stenosis (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED DeKalb Co. Mo.

IF NOT AT PLACE OF DEATH, _____

19. DID AN OPERATION PRECEDE DEATH? No. DATE OF _____

20. WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
Oscar L. Perkins, M.D.
(Signed) Oscar L. Perkins, M.D.

428 1928 (Address) Clarksdale, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Thornton Cemetery Apr 30 1928

20. UNDERTAKER ADDRESS

F. L. Low Stewartville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PERMANENT RECORD

USE OF DEATH IN THE

of the

of the

of the

of the

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County DeKalb Registration District No. 258 File No.
 Township Washington Primary Registration District No. 3360a Registered No.
 City No. St. Ward)

2. FULL NAME

Elijah Moore Groom
 (a) Residence. No. St. Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|--------------------|------------------------------|--|
| 3. SEX <u>M</u> | 4. COLOR OR RACE <u>W</u> | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>M</u> |
|--------------------|------------------------------|--|

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

| | | | | |
|--------|-------|--------|------|----------------------------------|
| 7. AGE | YEARS | MONTHS | DAYS | IF LESS than 1 day, hrs. or min. |
|--------|-------|--------|------|----------------------------------|

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
 (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
 (STATE OR COUNTRY)

14. INFORMANT
 (Address)

15. FILED Apr 29 1928 C. M. Davis REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4 - 28 19 28
 17. I HEREBY CERTIFY That I attended deceased from 19....., 19.....
 that I last saw h..... alive on....., 19....., and that
 death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Profusionalia - Tobar
 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) Prodenal ulcer and
mitral Stenosis (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH..... DATE OF.....
 WAS THERE AN AUTOPSY.....
 WHAT TEST CONFIRMED DIAGNOSIS.....
 (Signed)....., M. D.
 , 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

DEPARTMENT OF HEALTH

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