

FILED NOV 7 1942
Registration District No. _____

Primary Registration District No. 1000

Registrar's No. 825

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

1. PLACE OF DEATH:

(a) County Burgess
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Sisters
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 days (Specify whether _____)
In this community _____
years, months or days

8. (a) PRINT FULL NAME BESSIE MARIE HAVES

8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced MT
6. (b) Name of husband or wife Herman Groves 6. (c) Age of husband or wife if alive 49 years
7. Birth date of deceased March 27 1906
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>37</u>	<u>7</u>	<u>4</u>	hr. _____ min.

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

10. Usual occupation house wife

11. Industry or business

MOTHER FATHER
12. Name John Ball
13. Birthplace Mo Mo
(City, town, or county) (State or foreign country)
14. Maiden name Mary Beers
15. Birthplace Mo
(City, town, or county) (State or foreign country)

16. (a) Informant John H. Beers

(b) Address Union Star Mo

17. (a) Burial (b) Date thereof 11-3-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Star

18. (a) Signature of funeral director John H. Beers

(b) Address Clark'sdale Mo

19. (a) 11-3-42 (b) Roe Herzog
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County De Kalb
(c) City or town Union Star
(If outside city or town limit, write "RURAL")
(d) Street No. Route #2 (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 23
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Oct 23, 1942, to Oct 31, 1942;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Septic (Sept) Duration 4 days

Due to Cerebral py. following cerebral vag. degeneration

Other conditions Contracta pelvis 14 78
(Include pregnancy within 3 months of death)
prolonged labor, vag exam

Major findings: Tubercles of uterine -
Of operations _____
Of autopsy None

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) (e) Means of injury _____
23. Signature Dr. H. H. Beers (M. D. or other) _____
Address 670 Thence Date signed 11/4/42

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 me

Registered Apprentice No. _____

working under my personal supervision.

Signed

John P. Brown

Licensed Embalmer No. 3933

P. O. Address Chapel Hill, N.C.

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

State File No. 33220
Registrar's No. 820

Registration District No. 42 Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME Bessie Maud Gauer

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 m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased March 27
(Month) (Day) (Year)

8. AGE: Years 37 Months 2 Days _____ If less than one day _____ 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov year 1942 hour _____ minute 55 a M.

21. I hereby certify that I attended the deceased from Oct 31 1942 to Nov 3 1942 that I last saw him/her alive on Nov 3 1942 and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

Due to _____

Due to _____

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

Major findings:
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)

(b) 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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

