

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

Do not use this space.

1. PLACE OF DEATH

County Greene
Township Excelsior Springs
City Excelsior Springs (No. _____)

Registration District No. 198
Primary Registration District No. 3011

File No. _____
Registered No. 469
St. _____ Ward _____

20177

2. FULL NAME

William Riggs Grove

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

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Divorced

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 20 1854

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
74 0 29

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Gentry co
(STATE OR COUNTRY) MO

10. NAME OF FATHER Benjamin Grove

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

12. MAIDEN NAME OF MOTHER Adell

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

14. INFORMANT Jennie Turner
(Address) Excelsior Springs, MO

15. FILED 4/13 1928 Y. C. Craven
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 19 1928

17. I HEREBY CERTIFY That I attended deceased from June 1 1928, to June 19 1928 that I last saw him alive on June 19 1928, and that death occurred, on the date stated above, at 3 PM.

18. THE CAUSE OF DEATH* WAS AS FOLLOWS:
Stated cerebral hemorrhage
May 18 1928 while in
Arkansas - my first visit
June 1-28 (duration) yrs. mos. ds. 34
CONTRIBUTORY Arterial sclerosis
(SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? 7401
IF NOT AT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) John F. Grace M. D.

(Address) Excelsior Springs, 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 Excelsior Cemetery DATE OF BURIAL 6-20 1928

20. UNDERTAKER H. L. Hooper ADDRESS Excelsior Springs

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.

