

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MAR 28 1930

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

Do not use this space.

5521

1. PLACE OF DEATH

County Lafayette  
Township Dover  
City (No. .... St. .... Ward)

Registration District No. 460  
Primary Registration District No. 5623-03

File No. ....  
Registered No. 21

2. FULL NAME S. N. Groves

(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. 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 Anna Groves

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 18th 1862

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ... hrs. or ... min.  
68 --- 2

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

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

10. NAME OF FATHER A. J. Groves  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ohio  
(STATE OR COUNTRY)  
12. MAIDEN NAME OF MOTHER Mary Ann Oaker  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ohio  
(STATE OR COUNTRY)

14. INFORMANT Cassa M. Greening  
(Address) Higginsville, Mo.

15. FILED 2-23-30 Sissi P. Porter  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 21 1930

17. I HEREBY CERTIFY That I attended deceased from for two years to Feb 21, 1930 that I last saw him alive on Feb 21, 1930, and that death occurred, on the date stated above, at .....

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Cancer of Neck  
460

(duration) 2 yrs. .... mos. .... da.

CONTRIBUTOR (SECONDARY) (duration) ... yrs. .... mos. .... da.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH: ...

Did an OPERATION PRECEDE DEATH? ... DATE OF ...

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) M. G. Webb

(Address) Higginsville, 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 City Cemetary  
DATE OF BURIAL 2/23/30

20. UNDERTAKER ASHMAN  
ADDRESS Higginsville, Mo.

