

REC'D APR 13 1939

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

Do not use this space.

1. PLACE OF DEATH

County

Township

City

Registration District No.

Primary Registration District No.

File No.

Registered No.

St.

Ward)

2. FULL NAME

(a) Residence, No.

(Usual place of abode)

St.

Ward.

(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

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED, OR
DIVORCED (write the word)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.

OCCUPATION

8. Trade, profession, or particular
kind of work done, as spinner,
sawyer, bookkeeper, etc.9. Industry or business in which
work was done, as silk mill,
saw mill, bank, etc.10. Date deceased last worked at
this occupation (month and
year)11. Total time (years)
spent in this
occupation12. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

13. NAME

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

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)17. INFORMANT
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE

DATE

19. UNDERTAKER
(ADDRESS)

20. FILED

4-8

19

39

Fred Mull

MO

927

(Address)

Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 22 1939

22. I HEREBY CERTIFY, That I attended deceased from

June 10 1938, to Feb 22 1939

I last saw him alive on Feb 21 1939. Death is said

to have occurred on the date stated above, at 4 A. M.

The principal cause of death and related causes of importance were as follows:

Pneumonia exudativa

Date of onset

Other contributory causes of importance:

Name of operation

What test confirmed diagnosis? Pharyngeal Dissection

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

Charles H. Williams

(Address)

Gentry Mo

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

FORM 10-22-35
I X9314

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~~APR 12 1939~~

CORD

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FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

12723
Do not use this space.

1. PLACE OF DEATH

- (a) County North Registration District No. 1112
(b) Township Middlefork Primary Registration District No. 6213 Registered No. _____
(c) City _____ (d) Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

- Andrew Lincoln Grooms
(a) Residence, No. _____ St. ☐ (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

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) <u>Jan. 1, 1864</u>		
7. AGE	YEARS <u>75</u>	MONTHS <u>1</u>
	DAYS <u>21</u>	IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.	
	9. Industry or business in which work was done, as saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year)	
	11. Total time (years) spent in this occupation	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)		
FATHER	13. NAME	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	
MOTHER	15. MAIDEN NAME	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	
17. INFORMANT (ADDRESS)		
18. BURIAL, CREMATION, OR REMOVAL		
PLACE _____ DATE _____ 19		
19. FUNERAL DIRECTOR (ADDRESS)		
20. FILED <u>4/8</u> 19 <u>39</u> <u>2nd</u> <u>Mo</u> <u>Mo</u> Local Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR)	<u>2 - 22</u> 19 <u>39</u>
22. I HEREBY CERTIFY, That I attended deceased from 19____ to _____, 19____ I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m. The principal cause of death and related causes of importance were as follows: Date of onset _____ Other contributory causes of importance: _____ Name of operation _____ Date of _____ What test confirmed diagnosis? _____ Was there an autopsy? _____ 23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____ Where did injury occur? _____ (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place. _____ Manner of injury _____ Nature of injury _____ 24. Was disease or injury in any way related to occupation of deceased? _____ If so, specify _____ (Signed) <u>Chas. N. Williamson</u> , M.D. _____ (Address) <u>Sentry</u> <u>Mo.</u>	

THIS IS A SUPPLEMENTAL RECORD

WRITE PLAIN

50M-5-37
I X12241

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 COMPLETED AS PRESCRIBED BY LAW.

MAY 12 1933