

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.

MAY 16 1939

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

15064  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Jackson Registration District No. 398  
 (b) Township Independence Primary Registration District No. 3019 Registered No. 131  
 (c) City Independence (d) Street No. Independence Sanitarium 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 1 yrs. 7 mos. 3 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME William Anthony Gross  
 (a) Residence, No. 11415 East 19th St. 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Child

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 8, 1937

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
1 7 3

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. XXXXXXXXXXXXXXXXXXXX  
 9. Industry or business in which work was done, as saw mill, bank, etc. XXXXXXXXXXXXXXXXXXXX  
 10. Date deceased last worked at this occupation (month and year) XXXXXXXXXXXX  
 11. Total time (years) spent in this occupation XXXXXXXXXXXX

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Independence Missouri

FATHER  
 13. NAME P. S. Gross  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas City Missouri

MOTHER  
 15. MAIDEN NAME Evalyn Nickeon  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Independence Missouri

17. INFORMANT P. S. Gross  
 (ADDRESS) 11415 E. 19th St. Indep. Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Washington DATE Apr. 12, 1939

19. FUNERAL DIRECTOR (NAME) Henry W. Stahl  
 (ADDRESS) 815 W. Maple Ave. Indep. Mo.

20. FILED 4-17-39 F. L. Calk  
 Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr. 11, 1939

22. I HEREBY CERTIFY, That I attended deceased from April 5, 1939, to April 11, 1939  
 I last saw him alive on April 11, 1939. Death is said to have occurred on the date stated above, at 1:25A m.  
 The principal cause of death and related causes of importance were as follows:  
Appendicitis, Subintention type  
Embolic

Date of onset 4/6/39

Other contributory causes of importance: 121

Name of operation..... Date of.....  
 What test confirmed diagnosis?..... Was there an autopsy? No

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) Charles Nickeon Jr., M. D.  
 (Address) Independence Mo

---

---

**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 \_\_\_\_\_

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**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.**