

JUN 14 1940

Registration District No. 1104

Primary Registration District No. 5475 4554

Registrar's No. 8

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

1. PLACE OF DEATH:

(a) County Franklin

(b) City or town Gerald
(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 three days (Specify whether years, months or days)

3. (a) PRINT FULL NAME MAYNARD H GRUBE 1010

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

4. Sex male 5. Color or race white

6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased May 20 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 2 If less than one day _____ hr. _____ min.

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

10. Usual occupation Child

11. Industry or business _____

12. Name Herbert H. Grube

13. Birthplace Gerald Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Joan Fisher

15. Birthplace Bay Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Herbert Grube

(b) Address _____

17. (a) St Paul, Gerald (b) Date thereof May 23 1940
(Burial place) (Month) (Day) (Year)

(c) Place: burial or cremation St Paul, Gerald

18. (a) Signature of funeral director E. Meyer

(b) Address Gerald Mo 272

19. (a) 5-23-40 (b) Charles A. Schmitt
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Franklin

(c) City or town Gerald
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION.

20. DATE OF DEATH: Month May day 20
year 1940 hour 1 minute 0 A. M.

21. I hereby certify that I attended the deceased from May 20, 1940 to May 22, 1940
that I last saw him alive on May 21, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Congenital defect of gastrointestinal tract
Due to bleeding hemorrhage
Of unknown origin

Duration 2 days

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)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

(a) Means of injury _____

23. Signature [Signature] (S.D. or other) _____

*Address Gerald Mo Date signed 5/24/40

Handwritten notes and signatures, including the name "E. J. ...".

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.