

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **18981**
Registrar's No. **160**

Registration District No. **547** Primary Registration District No. **3029**

1. PLACE OF DEATH:

- (a) County Maxion
(b) City or town Hannibal
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Lexington Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 1/2 (Specify whether)

In this community _____ years, months or days

3. (a) PRINT FULL NAME Forrest W. Grier 660

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 Married

6. (b) Name of husband or wife Cora 6. (c) Age of husband or wife if alive 33 years

7. Birth date of deceased OCT. 26, 1901
(Month) (Day) (Year)

8. AGE: Years 39 38 Months 7 Days 3 If less than one day hr. _____ min. _____

9. Birthplace St Joseph, MO
(City, town, or county) (State or foreign country)

10. Usual occupation Telephone Director

11. Industry or business G

12. Name William Grier

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

14. Maiden name Frankie Woodard

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

16. (a) Informant's own signature Cora Grier

(b) Address 214 N 6th Hannibal MO

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 2-40
(Month) (Day) (Year)

(c) Place: burial or cremation Savannah MO

18. (a) Signature of funeral director James O'Connell

(b) Address Hannibal MO

19. (a) May 31, 1940 (Date received local registrar) (b) W. E. Fisher (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St Joseph MO
(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 29
year 1940 hour 9 minute 0 M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death Verdict of Jury

By Electrocution Source of Electricity

Due to Being 40 Kilowatts to Jury

Due to _____

Other conditions (Include pregnancy within 3 months of death) 140

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence 5/29/40

(c) Where did injury occur? Hannibal, Marion MO
(City or town) (County) (State)

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

While at work? yes (Specify type of place) (e) Means of injury Electric Dangers

23. Signature James O'Connell (M. D. or other) _____

Address Hannibal MO Date signed 5-31-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

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 Michael J. Poirel

Licensed Embalmer No. 3246

P. O. Address Hannibal Mo

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 18981

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 547

Primary Registration District No. 3029

Registrar's No. 160

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

1. PLACE OF DEATH:

(a) County Warren
(b) City or town Warren
(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 _____ (Specify whether)
years, months or days

3. (a) PRINT FULL NAME Farrest W. Grier

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased Oct-26-1901
(Month) (Day) (Year)

8. AGE: Years 38 Months 39 Days 7 3 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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 29
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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)
(e) Means of injury _____

23. Signature James O'Connell (M. D. or other) _____

Address Warren, Mo. Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-18981