

STANDARD CERTIFICATE OF DEATH

X23159

Registration District No. 194

Primary Registration District No. 3025

State File No. \_\_\_\_\_

Registrar's No. 85

1. PLACE OF DEATH:

(a) County Linn

(b) City or town Brookfield  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Mc Lary Hospital, Brookfield, Mo.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 40 Days  
(Specify whether)

In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Fredrick William Groes

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Wife

6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased October 17, 1940  
(Month) (Day) (Year)

8. AGE: Years 64 Months 5 Days 14  
If less than one day hr. min.

9. Birthplace Linn Co, Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Engineer-Merchant-Laborer

11. Industry or business \_\_\_\_\_

12. Name John Henry Groes

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

14. Maiden name Elizabeth Bittinger

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

16. (a) Informant X M Lucille Gross Engberg

(b) Address Laclede, Mo.

17. (a) Burial (b) Date thereof 10/18/1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Laclede, Mo.

18. (a) Signature of funeral director McTharrel

(b) Address Laclede, Mo. --- L.# 2876

19. (a) Oct 17 40 (b) Northward  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State 1 (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 Oct day 17  
year 1940 hour 1 minute 00 A. M.

21. I hereby certify that I attended the deceased from 9-9-40  
\_\_\_\_\_, 19\_\_\_\_, to 10-17, 1940;  
that I last saw him alive on 10-17, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Luxation - Gangrene of 1st leg. Following injury

Due to slip

Due to \_\_\_\_\_

Other conditions None  
(Include pregnancy within 3 months of death)

Major findings: Of operations None

Of autopsy 0

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

(a) Accident, suicide, or homicide (specify) fall down ✓

(b) Date of occurrence 7 5 wks -

(c) Where did injury occur? Laclede Linn Mo  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
445 - Fall from Public House

While at work? Yes (Specify type of place) \_\_\_\_\_  
(e) Means of injury fall

23. Signature John W. Lang (M. D. or other) \_\_\_\_\_  
Address Bonaparte Date signed 10/16/40

Duration

5 hrs

10 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

19412  
99

**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 Me

W.G. Thorne

, Registered Apprentice No. 2876

working under my personal supervision.

Signed

*W.G. Thorne*

Licensed Embalmer No. 2876

P. O. Address

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **35-720**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **496**

Primary Registration District No. **3025**

Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH:**  
 (a) County **Linn**  
 (b) City or town **Bronfield**  
 (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 \_\_\_\_\_ years, months or days)

**3. (a) PRINT FULL NAME** **Frederic Wm Groes**  
**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** \_\_\_\_\_ year

**7. Birth date of deceased** \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

**8. AGE:** Years **64** Months **5** Days **14** If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min.

**9. Birthplace** \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

**10. Usual occupation** \_\_\_\_\_

**11. Industry or business** \_\_\_\_\_

**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** **Mrs Lucille Groes Engberg**

**(b) Address** **Laclede**

**17. (a)** \_\_\_\_\_ **(b) Date thereof** \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

**(c) Place: burial or cremation** \_\_\_\_\_

**18. (a) Signature of funeral director** \_\_\_\_\_

**(b) Address** \_\_\_\_\_

**19. (a)** **101340** **(b) J. W. Lucas** (Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State **Mo** (b) County **Linn**  
 (c) City or town **Loeble 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.

**20. DATE OF DEATH** Month **Oct** day **17** year **1940** hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
**21. I hereby certify that I attended the deceased from** \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death **Totemo-Paronychia of it leg**  
 Due to **Following injury**

Due to **Dialysis**  
 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) **Abraction**  
 (b) Date of occurrence **7/11/40**  
 (c) Where did injury occur? **Loeble Mo** (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State) \_\_\_\_\_  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? **Home**  
 While at work? **Yes** (Specify type of place) \_\_\_\_\_ (c) Means of injury \_\_\_\_\_  
**23. Signature** **J. W. Lucas** (M. D. or other) \_\_\_\_\_  
 Address **Bronfield Mo** Date signed **10/17**

**MEDICAL CERTIFICATION**

**PHYSICIAN** \_\_\_\_\_

Duration **5 days**

Underline the cause to which death should be charged statistically.

**SUPPLEMENTAL**

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

MOTHER FATHER

