

Registration District No. 914

Primary Registration District No. 1235

Registrar's No. 6235-

1. PLACE OF DEATH:

(a) County Ray Co
 (b) City or town Shreve Grove Twp
 (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 5
 (Specify whether
 In this community 45 years
 years, months or days)

3. (a) PRINT FULL NAME Lee Grand Glover

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 Anna Alice Keller 6. (c) Age of husband or wife if alive 63 years
 7. Birth date of deceased May - 19 - 1867
 (Month) (Day) (Year)

8. AGE: Years 73 Months 6 Days 2 If less than one day _____ hr. _____ min.

9. Birthplace Rockingham Co Va
 (City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business _____

12. Name Lee Grand Glover

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

14. Maiden name Elizabeth Letholt

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

16. (a) Informant Mrs Frank Davis

(b) Address Hardin Mo

17. (a) Wakenda (b) Date thereof 11-24-40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wakenda, Mo

18. (a) Signature of funeral director Jno W. Knipschild

(b) Address Hardin, Mo

19. (a) Quez (b) Mrs Ina M. Maus
 (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. 5
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 21st
 year 1940 hour 11 minute A M.

21. I hereby certify that I attended the deceased from Oct 1, 1940 to Nov. 21, 1940
 that I last saw him alive on Nov 21, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy Duration 10 days

Due to _____
 Due to _____

Other conditions Uremic Poisoning 2 days
 (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?

(e) Means of injury _____
 23. Signature Dr. E. Q. Keran (Specify type of place) _____
 Address Richmond, Mo (e) _____
 Date signed Nov 22-40

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

MOTHER FATHER

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 12-9-40

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

....., Registered Apprentice No.

working under my personal supervision.

Signed John W. Knipschill

Licensed Embalmer No. 2789

P. O. Address Hardin 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39574

Registration District No. 914

Primary Registration District No. 6235

Registrar's No. _____

1. PLACE OF DEATH:
(a) County Ray
(b) City or town Grays Grove T.O.
(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 _____)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Ray
(c) City or town Grays Grove
(If outside city or town limits, write "RURAL")
(d) Street No. Journshp
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

In this community _____
years, months or days
3. (a) PRINT FULL NAME Lee Grand Glover
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov day 21
year 1940 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____
_____ 19 _____ to _____ 19 _____

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 _____
(Month) (Day) (Year)

that I last saw h _____ alive on _____ 19 _____
and that death occurred on the date and hour stated above.
Immediate cause of death _____
Duration _____

8. AGE: Years 73 Months 6 Days 2 If less than one day _____ hr. _____ min.

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

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 _____
(City, town, or county) (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Dec 2, 40 (b) M. J. Jackson
(Date received local registrar) (Registrar's signature)

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? _____

Major findings:
Of operations _____
Of autopsy _____
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature E. J. Berger (M-D or other) 17-20
Address Richmond Mo Date signed _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

(Licensed Embalmer's Statement on Reverse Side)
W. J. Jackson

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

2
-41
-39
K26390

1940
S-39574

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 the above constitutes grounds for revocation of license.)

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