

WHITE PAPER - 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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

14684

Registration District No. 347 Primary Registration District No. 3018 State File No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County Henry  
(b) City or town Clinton  
(c) Name of hospital or institution M. Water St  
(If outside city or town limits, write "RURAL" and name of township)  
(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 1 yr 6 mo

3. (a) PRINT FULL NAME Charles Henry Gregg  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Mar 4 1871  
(Month) (Day) (Year)

8. AGE: Years 70 Months 1 Days 10 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Laborer

11. Industry or business \_\_\_\_\_  
MOTHER FATHER { 12. Name Abraham Gregg  
13. Birthplace Cass Co Mo  
(City, town, or county) (State or foreign country)  
14. Maiden name Margaret Phares  
15. Birthplace Indiana  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature John L. Gregg  
(b) Address Clinton Mo

17. (a) Burial (b) Date thereof 4 18 41  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Creighton Mo

18. (a) Signature of funeral director Frank Williamson  
(b) Address Clinton Mo

19. (a) 4-19-41 (b) Dr. J. R. Hamilton  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Henry  
(c) City or town Clinton  
(If outside city or town limits, write "RURAL")  
(d) Street No. M Water St  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Apr day 14 year 1941 hour 3 minute 35 A.M.

21. I hereby certify that I attended the deceased April 14, 1941, to \_\_\_\_\_  
that I last saw him alive on April 14, 1941,  
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ Means of injury \_\_\_\_\_  
23. Signature Jay Smith (M. D. or other) \_\_\_\_\_  
Address Clinton Mo Date signed 4-16-41

RECEIVED

District Health Officer No. 7,

District File Number 5-41-879

Date Filed 5-13-41

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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. 2478

P. O. Address Clinton, N.Y.

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.