

S. N. 9-4-41
5-17-51
X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **7245**
Registrar's No. **22**

D MAR 8 1943 75

Registration District No. _____ Primary Registration District No. **3053**

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

1. PLACE OF DEATH:
 (a) County **Phelps**
 (b) City or town **Rolla**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
MacFarland Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **6 Days**
 (Specify whether _____)
 In this community _____
 years, months or days)

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

3. (a) PRINT FULL NAME **Fred A. Gritzner**
 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 **Widowed**
 6. (b) Name of husband or wife **Mary Gritzner** 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **10 9 1857**
 (Month) (Day) (Year)

8. AGE: Years **85** Months **3** Days **23**
 If less than one day _____ hr. _____ min.

9. Birthplace **Herman Missouri**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Retired**

11. Industry or business _____

MOTHER FATHER { 12. Name **Unknown**
 { 13. Birthplace **Unknown** 9
 (City, town, or county) (State or foreign country)
 { 14. Maiden name **Mary Weakley**
 { 15. Birthplace **Canada** 2
 (City, town, or county) (State or foreign country)

16. (a) Informant **Fred A. Gritzner, Jr.**

(b) Address **432 So. 9th, Lincoln, Nebraska**

17. (a) **Burial** (b) Date thereof **2/23/1943**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Dixon**

18. (a) Signature of funeral director **Fred H. Gilbert**

(b) Address **Dixon, Missouri**

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **February** day **22**,
 year **1943**, hour **2** minute **15** A. M.

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

that I last saw **him** alive on **February 22**, 19**43**, and that death occurred on the date and hour stated above.

Immediate cause of death **Myocarditis and mytral regurgatation.** Duration _____

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? _____

While at work? _____ (Specify type of place) (or) Means of injury _____

23. Signature **Fred H. Gilbert** (M. D. or other) _____

Address _____ Date signed _____

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.....
R/ 22943....., Registered Apprentice No.....
working under my personal supervision.

Signed Fred W. Gilbert

Licensed Embalmer No. 2341

P. O. Address Sixon 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. 72457
Registrar's No. 22

Registration District No. 270

Primary Registration District No. 3053

1. PLACE OF DEATH: Philps Rella

(a) County.....
 (b) City or town.....
 (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 Fred A. Grynner

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.....
 6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if
 7. Birth date of deceased. Oct 9 1900
 (Month) (Day) (Year)

8. AGE: Years 55 Months 3 Days 10 (If less than one day min.)

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

10. Usual occupation.....
 11. Industry of 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.....
 (b) Address.....
 17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
 (c) Place: burial or cremation.....

18. (a) Signature of funeral director.....
 (b) Address.....
 19. (a) 2-23-43 (b) [Signature]
 (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) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb year 1943 hour..... minute..... M.
 21. I hereby certify that I attended the deceased from..... 19.....
 that I last saw him..... live 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..... (M. D. or other).....
 Address..... Date signed.....

SUPPLEMENTARY

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

