

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

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

FILED AUG 9 1943  
Registration District No. 302

Primary Registration District No. 60414481

Registrar's No. 1455

1. PLACE OF DEATH:

(a) County Ripley

(b) City or town Mayfield (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

2. USUAL RESIDENCE OF DECEASED:

(a) State mo.

(b) County Ripley

(c) City or town Mayfield (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. 0 years.

3. (a) PRINT FULL NAME Dora Grove

(b) If veteran, name war \_\_\_\_\_

(c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month may day 27 year 43 hour 19 minute 40 A. M.

21. I hereby certify that I attended the deceased from may 20, 1943, to may 27, 1943 that I last saw he alive on may 20, 1943 and that death occurred on the date and hour stated above.

4. Sex fe 5. Color or race wh.

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

6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased nov. 14 1874 (Month) (Day) (Year)

Immediate cause of death angus Pectoris

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

Due to 94 f

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

8. AGE: Years Months Days If less than one day

68 6 13 hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

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

MOTHER FATHER

12. Name Stephen Kinney

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

14. Maiden name unknown

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

Major findings: Of operations no

Of autopsy no

PHYSICIAN \_\_\_\_\_ Underline the cause to which death should be charged statistically

16. (a) Informant's own signature Johal Grove

(b) Address Mayfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-31-43 (Month) (Day) (Year)

(c) Place: burial or cremation Canning Cem.

18. (a) Signature of funeral director W. H. Luby

(b) Address Canning Cem.

19. (a) 5-31-43 (Date received local registrar) (b) Paultha White (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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature STEPHEN KINNEY (M. D. or other) MD

Address Mayfield, Mo. Date signed 5/28/43

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.

RECEIVED

District Health Officer No. 5,

District File Number

743485 -

Date Filed

8-6-48

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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

*Delus Johnson*

Licensed Embalmer No.

4271

P. O. Address

*Canning Ark*

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.