

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

2
4-41
7-39
K29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **42923**
Registrar's No. **120**

FILED JAN 13 1944
Registration District No. **200**

Primary Registration District No. **3044**

1. PLACE OF DEATH:

(a) County **Macon**
(b) City or town **Macon**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1**
(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 **Jerome E. Grove**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **W**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Drury Grove**
6. (c) Age of husband or wife if alive **81** years
7. Birth date of deceased **May 9th 1866**
(Month) (Day) (Year)

8. AGE: Years **77** Months **5** Days **18**
If less than one day _____ hr. _____ min.

9. Birthplace **Perry Co. Ohio**
(City, town, or county) (State or foreign country)

10. Usual occupation **Barber**

11. Industry or business _____
12. Name **Wm J. Grove**

13. Birthplace **Ok.** (State or foreign country) **9**

14. Maiden name **Fannie**
15. Birthplace **Ok.** (State or foreign country) **9**

16. (a) Informant **Mrs Drury Waller**

(b) Address **Macon, Mo**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **10-31-43**
(Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Salem, Macon Co. Mo**

18. (a) Signature of funeral director **Stephen S. Goodling**
(b) Address **Macon, Mo.**
19. (a) **12/30/43** (Date received local registrar) (b) **Pea B. Hunkler** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Macon**
(c) City or town **Macon**
(If outside city or town limits, write "RURAL") **2**
(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 **Oct.** day **28**
year **1943** hour **3** minute **30** a. M.

21. I hereby certify that I attended the deceased from **Oct 23 1943** to **Oct 28 1943**
that I last saw him alive on **Oct 27 1943**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Coronary Disease**
Duration _____

Due to **Pneumonia**

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) (e) Means of injury **2**

23. Signature **A. C. Edwards** (Date of other) _____
Address **Macon Mo** Date signed **10/31/43**

1037

RECEIVED

District Health Officer No. 10

District File Number 1-44-140

Date Filed JAN 12 1944

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.....

O. L. Stephens

Licensed Embalmer No. 3057

P. O. Address Macon, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *Jan.*
Registrar's No. _____

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County *Macon*
(b) City or town *Macon*
(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

Jerome E. Grove

3. (b) If veteran, name was _____ 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 *May 9 1908*
(Month) (Day) (Year)

8. AGE: Years *77* Months *5* Days _____ If less than one day _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country) *Ohio*

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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (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 *Oct.* Day *28* Year *1943* Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Chronic Coronary Artery Disease
Pneumonia Lobars

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? _____

23. Signature *J. C. Church* (Specify type of place) _____ (e) Means of injury _____
Address *Macon, Mo.* Date signed *11/17/49*

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

SUPPLEMENTARY

S-42923