

No. 2
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5-17-39
X32673

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37687**
Registrar's No. **88**

FILED DEC 18 1944

Registration District No. **5478-4184** Primary Registration District No. **5478-4184**

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

1. PLACE OF DEATH:

(a) County Franklin

(b) City or town Gerald
(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 1
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. Main No. 77 S.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME GUSTAF H GROB

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 1

6. (b) Name of husband or wife Mary Louise Grob 6. (c) Age of husband or wife if alive 7.1 years

7. Birth date of deceased 7 30 1874
(Month) (Day) (Year)

8. AGE: Years 70 Months 3 Days 21 If less than one day hr. _____ min. _____

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

10. Usual occupation farmer

11. Industry or business _____

12. Name John H. Grob

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

14. Maiden name Marguerite Klemme

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

16. (a) Informant John H. Grob
(b) Address Gerald Mo

17. (a) Buried (b) Date thereof Nov 24-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Leslie Mo

18. (a) Signature of funeral director E. Meyer
(b) Address Gerald Mo

19. (a) 12-3-44 (b) Don Owen
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 21
year 1944 hour 2:45 minute A M.

21. I hereby certify that I attended the deceased from Nov 16 1944 to Nov 21 1944
that I last saw him alive on Nov 20 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Acute pyelo-nephritis Duration 5 da

Due to ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Other conditions (Include pregnancy within 3 months of death) General Arteriosclerosis

Major findings: No operation

Of operations _____

Of autopsy No 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) (c) Place of injury

23. Signature L. P. Macchewey, M.D. (M. D. or other) _____
Address Stearns Mo Date signed 1/7-44

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RECEIVED

District Health Officer No. 9,

District File Number _____

Date Filed

12-6-44

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. *Me.*

working under my personal supervision.

Signed

Robert M. Murray

Licensed Embalmer No.

3749

P. O. Address

Owensville, 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. Dec
Registrar's No. 88

Registration District No. 112 Primary Registration District No. 4184

1. PLACE OF DEATH:
(a) County Franklin
(b) City or town Sheldon
(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 Gustaf H Leah
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 m
6. (b) Name of husband or wife Leah 6. (c) Age of husband or wife if alive 71 years
7. Birth date of deceased July 30 1878
(Month) (Day) (Year)

8. AGE: Years 70 Months 3 Days _____ If less than one day _____ min.
9. Birthplace _____ (City, town, or county) (State or foreign country) mo.

10. Usual occupation _____
11. Industry or business _____

MOTHER FATHER
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) _____ (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) _____ (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 Nov Day 21 Year 1941 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____
that I last saw him _____ alive on _____ 19____
and that death occurred on the date and hour stated above.
Immediate cause of death _____
Duration _____

Due to Chronic Cystitis
Due to Chronic Prostatitis

Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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 _____
23. Signature J. Matthews M. D. or other _____
Address Beaumont Mo Date signed 12-17-41

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

SUPPLEMENTAL

37687