

FILED JAN 8 1945

Registration District No. _____

Primary Registration District No. **3009**

1. PLACE OF DEATH:

(a) County Cape Girardeau
(b) City or town Jackson
(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) 1
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 18 1/2 years, months or days

3. (a) PRINT FULL NAME

Carylon M Gross

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife George W. Gross 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased September 23 1869
(Month) (Day) (Year)

8. AGE: Years 75 Months 2 Days 16 If less than one day _____ hr. _____ min.

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

10. Usual occupation House wife

MOTHER FATHER

11. Industry or business _____
12. Name Julius Rose
13. Birthplace Germany (City, town, or county) (State or foreign country) 4
14. Maiden name Hannah Boese
15. Birthplace Germany (City, town, or county) (State or foreign country) 4

16. (a) Informant Ethel Gross
(b) Address Jackson Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 11 1944 (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park Cem

18. (a) Signature of funeral director William Staller Seaberg
(b) Address Jackson Mo
19. (a) 1/10 1944 (Date received local registrar) (b) J. H. Krumpholtz (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cape Girardeau
(c) City or town Jackson (If outside city or town limits, write "RURAL") 16
(d) Street No. _____ (If rural, give location) 1
(e) Citizen of foreign country? _____ (Yes or No) N
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 9 year 1944 hour 2 minute 10 P. M.
21. I hereby certify that I attended the deceased from Oct 1941 1941, to Dec 1944, and that death occurred on the date and hour stated above. Dec 9 1944

Immediate cause of death Myocarditis Duration 1 yr

Due to ?
Due to ?

Other conditions Cholecystitis 5 yr
(Include pregnancy within 3 months of death)

Major findings: Of operations 9.30
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 N
23. Signature TE Ruff (M. D. or other) MD
Address Jackson Mo Date signed 12-9-44

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

6
2
1

RECEIVED

District Health Officer No. 4

District File Number 145-14

Date Filed 1-5-45

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 Glen Wilson

Licensed Embalmer No. 2828

P. O. Address Jackson 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.