

FILED FEB 8 1945  
Registration District No. 19

Primary Registration District No. 5291

State File No. \_\_\_\_\_  
Registrar's No. 8

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

1. PLACE OF DEATH:  
(a) County. CLAY  
(b) City or town. LIBERTY TWP  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
L.O.O.F. Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. 0  
In this community. 2 yrs  
years, months or days) (Specify whether)

2. USUAL RESIDENCE OF DECEASED:  
(a) State. MO (b) County. Marion 64  
(c) City or town. Hamilton 3  
(If outside city or town limits, write "RURAL") 4  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country. \_\_\_\_\_

3. (a) PRINT FULL NAME. MARY E. GROVE  
3. (b) If veteran, name war. no  
3. (c) Social Security No. no

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month. January day. 26  
year. 1945 hour. 78 minute. 45 P.M.

4. Sex. F  
5. Color or race. W  
6. (a) Single, widowed, married, divorced. widow  
6. (b) Name of husband or wife. \_\_\_\_\_  
6. (c) Age of husband or wife if alive. \_\_\_\_\_ years  
7. Birth date of deceased. August 10 1863  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 1, 1942 to Jan 26, 1945 that I last saw her alive on Jan 26, 1945 and that death occurred on the date and hour stated above.

8. AGE: Years 81 Months 5 Days 16 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death. General Atherosclerosis 10 yrs. Duration

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

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions. \_\_\_\_\_  
(Include pregnancy within 3 months of death)

10. Usual occupation. Housewife

PHYSICIAN  
Major findings:  
Of operations. \_\_\_\_\_  
Of autopsy. \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER  
11. Industry or business \_\_\_\_\_  
12. Name. James Burns  
13. Birthplace. Canada IL  
(City, town, or county) (State or foreign country)  
14. Maiden name. Margaret Galivan  
15. Birthplace. St Louis MO  
(City, town, or county) (State or foreign country)

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? \_\_\_\_\_

16. (a) Informant. Victor G. Jennings  
(b) Address. Liberty MO  
17. (a) \_\_\_\_\_ (b) Date thereof. Jan 27-45  
(Burial, cremation, or reinterment) (Month) (Day) (Year)  
(c) Place: burial or reinterment. Terrace Hill Funeral Home  
18. (a) Signature of funeral director. Liberty MO  
(b) Address. \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury. \_\_\_\_\_

19. (a) Jan 27 1945 (b) Helen Early  
(Date received local registrar) (Registrar's signature)

23. Signature. Burton Walling (M. D. or other) M.D.  
Address. Liberty MO Date signed. 1-27-45

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 2-2-75

---

---

**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.....

Self....., Registered Apprentice No. \_\_\_\_\_,  
working under my personal supervision.

Signed Victor E. Jennings.....

Licensed Embalmer No. 2896.....

P. O. Address Liberty 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.**