No. 7
1-4-41
5-17-39
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 6 1945

Registration District No. 8W

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

5984

State File No.

Primary Registration District No. 3017

Registrar's No. 23

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

1. PLACE OF DEATH:
(a) County: COOPER
(b) City or town: BOONVILLE
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: VAN RAVENSWAY CLINIC
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 4 DAYS (Specify whether years, months or days)
In this community: 4 days

2. USUAL RESIDENCE OF DEACESED:
(a) State: MO (b) County: MORGAN
(c) City or town: RURAL (If outside city or town limits, write "RURAL")
(d) Street No.: N.W. STOVER (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country: ✓

3. (a) PRINT FULL NAME: LOUIS GROTHER
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: SINGLE
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: AUG (Month) 3 (Day) 1870 (Year)

8. AGE: Years 74 | Months 6 | Days 14 | If less than one day: hr. min.

9. Birthplace: COLE CAMP (City, town, or county) MO. (State or foreign country)
10. Usual occupation: FARMER
11. Industry or business:
MOTHER FATHER
12. Name: JOHN GROTHER
13. Birthplace: COLE CAMP (City, town, or county) MO. (State or foreign country)
14. Maiden name: MARY GERKEN
15. Birthplace: COLE CAMP (City, town, or county) MO. (State or foreign country)
16. (a) Informant: MRS. JAMES KASTOFER
(b) Address: STOVER MO.
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: FEB. 20 1945 (Month) (Day) (Year)
(c) Place: burial or cremation: STOVER CEM
18. (a) Signature of funeral director: J. F. Kleiman
(b) Address: Stover Mo.
19. (a) Feb-22-45 (Date received local registrar) (b) Dr Chas. Swap. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB day 17th year 1945 hour 2 minute P. M.
21. I hereby certify that I attended the deceased from Feb 14 1945 to Feb 17 1945 that I last saw him alive on Feb 16 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pneumonia + 2 hours	
Due to: accident	
Due to:	
Other conditions (Include pregnancy within 3 months of death): ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED	
Major findings: Of operations: none	
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): accident
(b) Date of occurrence: Feb 12. 1945
(c) Where did injury occur? Stover (City or town) Mo (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? on farm. (Specify type of place)
While at work? yes (e) Means of injury:
23. Signature: H. Rawmaway (M. D. or other) MD
Address: Bonville Mo Date signed 2-18-45

(Licensed Embalmer's Statement on Reverse Side)

10 FM

RECEIVED
District Health Officer No. 8,
3-5-45

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 J. L. Stevinson

Licensed Embalmer No. 4073

P. O. Address Stove, 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.

S. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. March

Registration District No. 82 Primary Registration District No. 3017 Registrar's No. 23

1. PLACE OF DEATH:

(a) County Cooper

(b) City or town Boonville
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
E. A Van Ravenswaay Clinic. Boonville Mo
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution from 2/14/45 – 2/17/45 (Specify whether
In this community
years, months or days)

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

3. (a) PRINT FULL NAME Louis Grother

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 S

6. (b) Name of husband or wife

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

7. Birth date of deceased Aug (Month) 3 (Day) 1870 (Year)

8. AGE: Years 74 Months 6 Days 14 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 17
year 1945 hour 12 minute 45 A.M.

21. I hereby certify that I attended the deceased from 2/14-/45, 19 to 2/17, 1945;
that I last saw him alive on 2/16, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia + Weak Heart
Had also 2 broken ribs.

Due to Infection
no other information

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations ./.
Of autopsy ./.

195 e
41

Duration

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) no.

(b) Date of occurrence Patient could not give information

(c) Where did injury occur? Sent in in unconscious condition (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? ./.
(Specify type of place)
While at work? ./. (e) Means of injury ./.

23. Signature A. Van Ravenswaay (M. D. or other) Mo
Address Boonville Mo Date signed 3-18-45

SUPPLEMENTARY

5944