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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

30923

State File No. \_\_\_\_\_

FILED OCT 15 1945  
Registration District No. 187

Primary Registration District No. 3040

Registrar's No. 120

1. PLACE OF DEATH:

(a) County Livingston

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

(c) Name of hospital or institution 115 Milwaukee St. 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 Life  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Livingston 59

(c) City or town Chillicothe 1  
(If outside city or town limits, write "RURAL")

(d) Street No. 115 Milwaukee St. 2  
(If rural, give location) 0

(e) Citizen of foreign country? ✓ (Yes or No) 0  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME James H. Grann

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 7  
year 1945 hour 11 minute 40 A.M.

21. I hereby certify that I attended the deceased from 8-1-1945, 19\_\_\_\_, to 9-7-45, 19\_\_\_\_,  
that I last saw him live on 9-6, 19\_\_\_\_, at 45  
and that death occurred on the date and hour stated above.  
Immediate cause of death Cerebral hemorrhage Duration \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Pearl Grann 6. (c) Age of husband or wife if alive 78 years

7. Birth date of deceased May 2, 1865  
(Month) (Day) (Year)

Due to Hypertension

Due to \_\_\_\_\_

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

Major findings: Of operations (30)

Of autopsy None

8. AGE: Years 80 Months 4 Days 5 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

9. Birthplace Livingston Co. Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Railroader Retired

11. Industry or business \_\_\_\_\_

12. Name Quanas Grann

13. Birthplace Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Farah Breese

15. Birthplace Illinois  
(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 Louis V. Grann

(b) Address Long Beach, California

17. (a) Burial (b) Date thereof 19/9/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hillboro, Cal. - Gospel, Mo.

18. (a) Signature of funeral director Donald P. Jordan

(b) Address Chillicothe, Mo.

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

While at work Reuben Barney (Specify type of place) (a) Means of injury M.D.

23. Signature Reuben Barney (M. D. or M. B.)  
Address Chillicothe Mo Date 8-8-45

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

1514

RECEIVED  
District Health Officer No. 11,  
District File Number \_\_\_\_\_  
Date Filed \_\_\_\_\_

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 Wayne J. Rollins  
Licensed Embalmer No. 1164  
P. O. Address Chillicothe 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.

Registration District No. 187,

Primary Registration District No. 3040

Registrar's No. 120

1. PLACE OF DEATH:

(a) County Livingson  
(b) City or town Chillicothe  
(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 Life  
years, months or days)

3. (a) PRINT FULL NAME James H. Gunn

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 married

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased May 2, 1945  
(Month) (Day) (Year)

8. AGE: Years 80 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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 \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) Sept 8, 1945 (b) James B. Neill  
(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 \_\_\_\_\_ day \_\_\_\_\_ year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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 \_\_\_\_\_

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 \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

MOTHER FATHER

35923