S. No. 2
I—8-43
5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 17 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

34166

State File No.

Registration District No. 199 Primary Registration District No. 4311 Registrar's No. 10

1. PLACE OF DEATH:

(a) County Macon

(b) City or town Callao
(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 All her life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macon 61

(c) City or town Callao 0
(If outside city or town limits, write "RURAL")

(d) Street No. — 0
(If rural, give location) 0

(e) Citizen of foreign country? — (Yes or No)

If yes, name country —

3. (a) PRINT FULL NAME Olive Judith Grove

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex Female

5. Color or race wh

6. (a) Single, widowed, married, divorced w-y

6. (b) Name of husband or wife —

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

7. Birth date of deceased Aug (Month) 30 (Day) 1873 (Year)

8. AGE: Years 72 Months 0 Days 6 If less than one day hr. min.

9. Birthplace Callao (City, town, or county) Mo 0 (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name H. P. Benning
13. Birthplace (City, town, or county) Mo 0 (State or foreign country)

MOTHER
14. Maiden name Mary Ellen Collier
15. Birthplace (City, town, or county) Mo 0 (State or foreign country)

16. (a) Informant Anna Benning
(b) Address Callao Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-8-45 (Month) (Day) (Year)
(c) Place: burial or cremation Locust Grove Cem

18. (a) Signature of funeral director H G Edwards
(b) Address Bevier Mo

19. (a) Sept 13, 1945 (Date received local registrar) (b) W F Allen (Registrar's signature)

1043

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 6
year 1945 hour 5 minute 30 P M.

21. I hereby certify that I attended the deceased from SEPT 3, 1945 to SEPT 3, 1945
that I last saw her alive on Sept 3, 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary Thrombosis	1 hr
Due to —	
Due to —	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations —	
Of autopsy No	

940

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

22. If death was due to external causes, fill in the following:

(c) 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? — (Specify type of place)

While at work? — (e) Means of injury —

23. Signature: O O West (M. D. or other)

Address New Amsterdam Mo Date signed Sept 12 1945

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 10-45-1535
Date Filed OCT 16 1945

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 D. G. Edwards

Licensed Embalmer No. 1961

P. O. Address Bevier 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.