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FILED FEB 11 1946 STANDARD CERTIFICATE OF DEATH

State File No. 3092

Registration District No. 164

Primary Registration District No. 3022

Registrar's No. 128

1. PLACE OF DEATH:

(a) County Johnson  
(b) City or town Warrensburg  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
222 E Culton St  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution none  
(Specify whether years, months or days)  
In this community 60 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Johnson 51  
(c) City or town Warrensburg 2  
(If outside city or town limits, write "RURAL")  
(d) Street No. 222, East Culton 2  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME George Marr Grainger

3. (b) If veteran, name war no 3. (c) Social Security No. no

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

6. (b) Name of husband or wife Becca Grainger 6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased July 24 1878  
(Month) (Day) (Year)

8. AGE: Years 67 Months 5 Days 26  
If less than one day hr. min.

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

10. Usual occupation Retired Farmer

11. Industry or business

MOTHER } 12. Name James Grainger  
FATHER } 13. Birthplace Unknown unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Mattie Marr  
15. Birthplace Johnson Co Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Becca Grainger  
(b) Address Warrensburg, MO.

17. (a) Burial (b) Date thereof Jan. 22, 46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Sunset Hill Cem.

18. (a) Signature of funeral director Sweeney Phillips  
(b) Address Warrensburg, MO.

19. (a) 1/22/46 (b) Savannah Cutchfield  
(Date received local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 20  
year 1946 hour 8 minute 30 A. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_ 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 Gun shot wound in the right temple. Poor health had worry.  
Due to Self inflicted.

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 164  
Of autopsy

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) Suicide  
(b) Date of occurrence Jan. 20, 1946  
(c) Where did injury occur? 222 Culton, Twp, Mo.  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
In the basement of his home.  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury Revolver, County Corner  
23. Signature J May Andrews (or other)  
Address Holden, Mo. Date signed 1/22/46

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

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**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. Earl Priest  
Licensed Embalmer No. 3878  
P. O. Address Warrensburg, 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. 164 Primary Registration District No. 2022

1. PLACE OF DEATH:

(a) County Johnson

(b) City or town Warsawburg  
(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 years, months or days)

In this community \_\_\_\_\_ (Specify whether years, months or days)

3. (a) PRINT FULL NAME George M. Chandler

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 \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased \_\_\_\_\_  
(Month) (Day) (Year)

8. AGE: Years 67 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

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)

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

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

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

19. (a) Jan 22, 1946 (b) Lawrence D. [Signature]  
(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 1946 (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 \_\_\_\_\_

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

SUPPLEMENTARY

3092