

FILED MAY 8 1947

Registration District No. **72**

Primary Registration District No. **3289**

Registrar's No. **54**

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

1. PLACE OF DEATH:

(a) County Clay

(b) City or town Rural, RR#10 N.K.C., MO
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None (Specify whether)

In this community All her life
years, months or days)

3. (a) PRINT FULL NAME IRENE CLIFTON GROVES

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Lafette Groves

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

7. Birth date of deceased July 24 1870
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day	
76	8	28	X	X
			hr.	min.

9. Birthplace Clay County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Home

12. Name Robert Oldham

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

14. Maiden name Unknown

15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Anna Boydston

(b) Address 719 Harrison, K.C., Mo.

17. (a) Burial (b) Date thereof 4/25/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forben Cemetery Linden

18. (a) Signature of funeral director Morton Smith's F.H.

(b) Address 832 Armour Rd. North Kansas City

19. (a) April 25 - 47 (b) Beulah Kitchener
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clay

(c) City or town North K.C. Rural
(If outside city or town limits, write "RURAL")

(d) Street No. R.R. 10 North Kansas City
(If rural, give location)

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

If yes, name country XXXX

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 22
year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Nov 9 1946 to April 19 1947
that I last saw her alive on April 19 1947
and that death occurred on the date and hour stated above.

Immediate cause of death coronary heart disease

Duration	<u>4-5 yrs</u>
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Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations 94A

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 _____

Signature J. Charles Tom (M. D. or other) MD

Address Community Bldg No. 101 Date signed 4/24/47

RECEIVED

District Health Officer No. 8.

District File Number

Date Filed

5-7-47

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

Theron Smith

Licensed Embalmer No.

3928

P. O. Address

North Knoxville

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.