

Registration District No. _____

Primary Registration District No. 3000

Registrar's No. 254

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Hicksville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Grain Smith Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 weeks
(Specify whether years, months or days) 35 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Schuyler
(c) City or town Queen City
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME OLIVER PETER GROW

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

4. Sex M 5. Color or race White 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife Cynthia Grow 6. (c) Age of husband or wife if alive 57 years
7. Birth date of deceased Feb 29 1874
(Month) (Day) (Year)

8. AGE: Years 71 Months 6 Days 24 If less than one day hr. min.

9. Birthplace Decatur Co Ind
(City, town, or county) (State or foreign country)

10. Usual occupation Osteopathic Physician

11. Industry or business " " " "

12. Name Peter C Grow

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

14. Maiden name Lizzie Young

15. Birthplace Ripley Co Ind
(City, town, or county) (State or foreign country)

16. (a) Informant D. H. Grow

(b) Address Belvid Wisconsin

17. (a) Burial (b) Date thereof Sept 16 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Queen City Mo

18. (a) Signature of funeral director OWN N WRSK

(b) Address Queen City MO

19. (a) Sept 16-47 (b) Kate Lambert
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 14th
year 1947 hour 2 minute 25 A.M.

21. I hereby certify that I attended the deceased from August 9th, 1947, to Sept 14th, 1947, that I last saw him alive on Sept 13, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death Bronchogenic Carcinoma Duration 2 mo.

Due to _____

Due to _____

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

Major findings: Of operations 472
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 George E. Grim (M. D. or other) MD

Address Hicksville, Missouri Date signed 9/14/47

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

MOTHER FATHER

APR 8 1948

RECEIVED
District Health Officer No. 9-47-12
District File
Date Filed SEP-23-1947

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 Self

....., Registered Apprentice No.
working under my personal supervision.

Signed William M. West
Licensed Embalmer No. 2882
P. O. Address Full City, 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.