

FILED OCT 13 '47

Registration District No. **42**

Primary Registration District No. **1000**

Registrar's No. **1181**

1. PLACE OF DEATH

(a) County **Buchanan**
(b) City or town **St. Joseph**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Missouri Methodist Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5 days** (Specify whether
In this community **5 days** years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Nodaway 74**
(c) City or town **Skidmore**
(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 **Charles Edward Groves**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Mrs. Alice Bagby Groves** 6. (c) Age of husband or wife if alive **68** years
7. Birth date of deceased **March 1-1875** (Month) (Day) (Year)

8. AGE: Years **73** Months **6** Days **13** If less than one day _____ hr. _____ min.

9. Birthplace **Maitland Mo** (City, town, or county) (State or foreign country)

10. Usual occupation **farmer & stockman**

11. Industry or business _____

MOTHER FATHER { 12. Name **Thomas Groves**
13. Birthplace **Mo.** (City, town, or county) (State or foreign country)
14. Maiden name **Cathie Linville**
15. Birthplace **Mo.** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Charles Groves**

(b) Address **Skidmore, Mo.**

17. (a) **Burial** (b) Date thereof **9-16-47** (Month) (Day) (Year)

(c) Place: burial or cremation **Prairie View Cem.**

18. (a) Signature of funeral director **G.M. Atchison**

(b) Address **Maryville, Mo.**

19. (a) **10-6-47** (b) **W. B. Jenkins** (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **14** year **1947** hour **9:15** minute **AM** M.

21. I hereby certify that I attended the deceased from **June 1936** 19... to **9-14-47** 19...; that I last saw him alive on **9-14-47** 19...; and that death occurred on the date and hour stated above.

Immediate cause of death **Calanary thrombosis** Duration **30 min**

Due to **Generalized arteriosclerosis by**

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

Major findings: Of operations _____ Of autopsy **747** 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 **St. Joseph Mo** (M. D. or other)

Address **St. Joseph Mo** Date signed **9-15-47**

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

to call
20

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 *G. M. Atkinson*

Licensed Embalmer No. 2279

P. O. Address Maryville, 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.