

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED MAR 29 1948
Registration District No. 171

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 8172
Registrar's No. 41

Primary Registration District No. 3012

1. PLACE OF DEATH:

(a) County Clay
(b) City or town Excelsior Springs, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Veterans Administration Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 yr. 24 days
In this community 1 yr. 24 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Leland J. Grow

3. (b) If veteran, name war World War I
3. (c) Social Security No. 495 09 6665

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Helen Grow
6. (c) Age of husband or wife if alive 45 years
7. Birth date of deceased August 17 1895
(Month) (Day) (Year)

8. AGE: Years 52 Months 6 Days 29
If less than one day hr. min.

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

10. Usual occupation not employed

11. Industry or business

12. Name James M. Grow
13. Birthplace Kentucky
(City, town, or county) (State or foreign country)
14. Maiden name Rozanna Burton
15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records, Veterans Administration Hospital
(b) Address Excelsior Springs, Missouri
17. (a) Removal (b) Date thereof 3-17/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation Removal Trenton, Missouri
18. (a) Signature of funeral director Class O Hope
(b) Address Excelsior Springs, Mo.
19. (a) 3-17-48 (b) Barbara Hutchings
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Grundy
(c) City or town Trenton
(If outside city or town limits, write "RURAL")
(d) Street No. 1914 Mabel
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 16
year 1948 hour 10:50 minute P. M.

21. I hereby certify that I attended the deceased from February 22, 1947, to March 16, 1948,
that I last saw him alive on March 16, 1948,
and that death occurred on the date and hour stated above.

Immediate cause of death
Tuberculosis, pulmonary, reinfection
type, far advanced, active

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy No autopsy performed

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 1

23. Signature S.C. Stroff (M. D. or other) M. D.
Address Veterans Administration Hospital
Excelsior Springs, Mo.

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed 3-26-48

OCT 26 1949

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

James A. Moles

Licensed Embalmer No.

3296

P. O. Address

Exp Springs 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.