

S. No. 300
M-10-47
y. 5-17-39
I 3906

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

13099

FILED MAY 5 1948
Registration District No. _____

Primary Registration District No. 2001

State File No. _____
Registrar's No. _____

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

1. PLACE OF DEATH:
(a) County Jasper
(b) City or town Joplin
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Johns Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution MAR 24, 1948 - Hosp
In this community Life
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jasper
(c) City or town Webb City
(If outside city or town limits, write "RURAL")
(d) Street No. 724 S. Madison
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Rose Mahalla McGrew
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 5
year 1948 hour 10:45 minute A M.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Husband
Avery G. McGrew 6. (c) Age of husband or wife if alive 67 years
7. Birth date of deceased August 5 1884
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Dec 5
1948 to April 5 1948
that I last saw her alive on April 5 1948
and that death occurred on the date and hour stated above.

8. AGE: Years 63 Months 7 Days 26
If less than one day hr. _____ min. _____

Immediate cause of death CARDIAC FAILURE Duration 36 hrs
Due to Myocarditis Unk.

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

Due to CARCINOMA OF PANCREAS Unk.

10. Usual occupation Housewife

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

11. Industry or business _____

Major findings: Obst of Scurdenum PHYSICIAN _____
Of operations _____ Underline the cause to which death should be charged statistically.

12. Name James Wheller

Of autopsy H & B

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

14. Maiden name Maggie Faulkner

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

16. (a) Informant Avery G. McGrew

(b) Address 724 S. Madison, Webb City, Mo.

17. (a) Burial (b) Date thereof April 8, 48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Hope Cem
JOHNSTON-ARNCE-SIMPSON

18. (a) Signature of funeral director _____
(b) Address Webb City, Missouri

22. If death was due to external causes, fill in the following:

19. (a) 4-2-48 (b) Delores Simpson
(Date received local registrar) (Registrar's signature)

(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 Carol J. Needels (M. D. or other) MD

Address Webb City Mo Date signed 4-6-48

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.....

Jack C. Simpson

Registered Apprentice No. *38*

working under my personal supervision.

Signed

Harvey Orme

Licensed Embalmer No. *4463*

P. O. Address. *Web 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.