

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

39632

State File No. \_\_\_\_\_

Registration District No. 23

Primary Registration District No. 3014

Registrar's No. 108

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

1. PLACE OF DEATH:

(a) County Clay

(b) City or town Liberty  
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community 2 years  
years, months or days

3. (a) PRINT FULL NAME Harry Chappell Groom

3. (b) If veteran, name war World War I

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 Mary Martin Groom

6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased: Dec 22 1888  
(Month) (Day) (Year)

8. AGE: Years 59 Months 11 Days 21 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace De Kalb Co. Mo. U.  
(City, town, or county) (State or foreign country)

10. Usual occupation Contractor

11. Industry or business Development

MOTHER FATHER { 12. Name Michael Farmer Groom

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

14. Maiden name Lutie Chappell

15. Birthplace De Kalb Co. Mo. U.  
(City, town, or county) (State or foreign country)

16. (a) Informant Olin Jones

(b) Address Liberty Mo

17. (a) Burial (b) Date thereof 12/16/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Keasney Mo

18. (a) Signature of funeral director [Signature]

(b) Address Liberty Mo

19. (a) 12-16-1948 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Clay

(c) City or town Liberty  
(If outside city or town limits, write "RURAL")

(d) Street No. 438 Moss Ave  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 13  
year 1948 hour 3 minute 00 P.M.

21. I hereby certify that I attended the deceased from July 1948 to Dec 13 1948  
that I last saw him alive on Dec 10 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Occlusion & Myocardial Infarction

Due to Coronary Sclerosis - severe

Due to \_\_\_\_\_

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_  
Of autopsy: 940

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? 0

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address Liberty, Mo Date signed 12/13/48

Duration

Subs

Subs

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 12-30-42

OCT 27 1942

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 \_\_\_\_\_

Licensed Embalmer No. 3934

P. O. Address Liberty, 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.