

FILED FEB 11 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 527
Registrar's No. 8

BIRTH NO. _____ REG. DIST. NO. 55 PRIMARY REG. DIST. NO. 304

1. PLACE OF DEATH a. COUNTY <u>Carroll</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Chariton</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Carrollton</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Dalton</u>	
c. LENGTH OF STAY (in this place) <u>Two Days</u>		d. STREET ADDRESS (If rural, give location) _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Southside Hospital</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Arlene</u> b. (Middle) <u>Rhoda</u> c. (Last) <u>Grotjan</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 27 1949</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 22, 1916</u>
9. AGE (in years last birthday) <u>32</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 1 HR. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Valentine, Nebraska</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13a. FATHER'S NAME <u>Herman Koehler</u>		13b. MOTHER'S MAIDEN NAME <u>Ellen (unknown)</u>	
14. NAME OF HUSBAND OR WIFE <u>Wilbur Grotjan</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT'S SIGNATURE OR NAME <u>Wilbur Grotjan</u> ADDRESS <u>Dalton, Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Lymphatic Leukemia</u> ANTECEDENT CAUSES <u>Acute Lymphatic leukemia</u> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>✓</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m. _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>Dec 27, 1948</u> to <u>Jan 27, 1949</u> , that I last saw the deceased alive on <u>Jan 27, 1949</u> , and that death occurred at <u>5:40 p.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>J. L. Feister</u> (Degree or title) <u>Dr.</u>		23b. ADDRESS <u>Brunswick Mo</u>	
23c. DATE SIGNED <u>Jan 29-49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Jan 29, 49</u>	
24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) <u>Sunnyside, Washington</u>	
DATE REC'D BY LOCAL REG. <u>1/31/49</u>		REGISTRAR'S SIGNATURE <u>45</u> <u>Don Herbert Carter</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Meyer</u>		ADDRESS <u>Brunswick, Mo</u>	

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

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RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 2-10-49

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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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed A. L. Leipard

Signed _____
Student Embalmer

Licensed Embalmer No. 3970

P. O. Address Mendon Me

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.