

FILED SEP 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26692

State File No.

BIRTH NO. _____ REG. DIST. NO. 121 PRIMARY REG. DIST. NO. 5459 Registrar's No. 49

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>GREENE</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL 1ST CENTER</u>	c. LENGTH OF STAY (In this place) <u>3 Yrs</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL 1ST CENTER</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Rt. #6 SPGFD. Mo.</u>		d. STREET ADDRESS (If rural, give location) <u>Rt. #6 SPGFD. Mo.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>CECIL</u> b. (Middle) _____ c. (Last) <u>GROVES</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>SEPT. 6 1949</u>
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>DIVORCED</u>	8. DATE OF BIRTH <u>16 SEPT. 1903</u>	9. AGE (In years last birthday) <u>46</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 1 HR. Hour _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	11. BIRTHPLACE (State or foreign country) <u>MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>CHARLES GROVES</u>	13b. MOTHER'S MAIDEN NAME <u>MINNIE SMITH</u>	14. NAME OF HUSBAND OR WIFE _____
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or date of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>500-09-8393</u>	17. INFORMANT'S SIGNATURE OR NAME <u>MRS. BERTHA GOODWIN</u>	ADDRESS <u>SPGFD. Mo.</u>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>gun shot wound thru Heart</u> ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) _____ rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>5776x</u>	

19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>suicide</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>1st Center Twp Greene Mo.</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>9 12 49 9p.</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>22 cal gun shot thru hear t--self inflicted</u>
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased deceased 9/2/49, 1949 and that death occurred at 9 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Handwritten Signature Coroner</u>	23b. ADDRESS <u>Springfield, Mo.</u>	23c. DATE SIGNED <u>9/3/49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>9-4-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>MOUNT COMFORT CEMETERY</u>	24d. LOCATION (City, town, or county) (State) <u>NEAR SPRINGFIELD, Mo.</u>
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DATE RECD BY LOCAL REG. <u>9/8/49</u>	REGISTRAR'S SIGNATURE <u>Trene H. Wilson</u>	104	25. FUNERAL DIRECTOR'S SIGNATURE <u>J.W. Klingner + Co.</u>	ADDRESS <u>Spfld. Mo.</u>
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(Licensed Embalmer; Statement on Reverse Side)

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

RECEIVED

Greene County Health Office,

County File Number 49-57-9

Date Filed 9-12-49

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 _____

working under my personal supervision.

Student Embalmer No. _____

Signed.....
Student Embalmer

Signed

Max Rhodes

Licensed Embalmer No. 4071

P. O. Address *Springfield*

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.