

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

40308

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

FILED JAN 13 1951

036

BIRTH NO. _____		REG. DIST. NO. <u>112</u>		PRIMARY REG. DIST. NO. <u>5428</u>		Registrar's No. <u>42</u>	
1. PLACE OF DEATH a. COUNTY <b>Franklin</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Franklin</b>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rural- Boone</b>		c. LENGTH OF STAY at this place <b>6 years</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rural- Boone</b>		c. 36	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Sullivan, Missouri</b>				d. STREET ADDRESS (If rural, give location) <b>Sullivan, Missouri</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>George</b> b. (Middle) _____ c. (Last) <b>Groves</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Dec 16, 1950</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Divorced</b>	8. DATE OF BIRTH <b>Nov. 17, 1887</b>		9. AGE (In years last birthday) <b>63</b>	IF UNDER 1 YEAR Months <b>29</b> Days _____	IF UNDER 18 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cable Business</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Cable, Steel</b>		11. BIRTHPLACE (State or foreign country) <b>Akin, Illinois.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Alfred Groves</b>			13b. MOTHER'S MAIDEN NAME <b>Roxanna Pryer</b>		14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Evelyn Flanagan, Sullivan, Mo.</b>			ADDRESS
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.	<p align="center"><b>MEDICAL CERTIFICATION</b></p> <p>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <i>Cerebral Thrombosis</i></p> <p>ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____</p> <p>II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>332X</b></p>					INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
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)		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 _____, 19____, to <u>Dec 16</u> , 19 <u>50</u> ; that I last saw the deceased alive on <u>Dec 16</u> , 19 <u>50</u> , and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <i>D. L. W. Sullivan, M.D.</i>				23b. ADDRESS <b>Sullivan, Mo.</b>		23c. DATE SIGNED <b>12/18/50</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>12-19-50</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Cave Spring Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Franklin Co. Mo.</b>		
DATE REC'D BY LOCAL REG. <b>Jan 18 50</b>		REGISTRAR'S SIGNATURE <i>M. L. Matthews</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Thos. P. Chaffer</i>		ADDRESS <b>Sullivan Mo</b>	

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

File No. \_\_\_\_\_  
DISTRICT HEALTH OFFICE No. 4

JAN-8 1951

RECEIVED

JAN 17 1951

JAN 13 1951

**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 J. A. Humphrey

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 4772

P. O. Address Sullivan, 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.