

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED JAN 30 1953

BIRTH NO. _____ REG. DIST. NO. 150 PRIMARY REG. DIST. NO. 5592 Registrar's No. 24

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Prarie		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City 3028	
c. LENGTH OF STAY (in this place) 3 mo.		d. STREET ADDRESS (If rural, give location) 105 East 5th. Street	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jackson County Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) John	b. (Middle) B.	c. (Last) Groves	4. DATE OF DEATH (Month) (Day) (Year) Jan. 21, 1953
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower Divorced	8. DATE OF BIRTH Jan. 1, 1865	9. AGE (In years last birthday) 88	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Henrysburg, Ohio	12. CITIZENSHIP OF WHAT COUNTRY? USA
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13a. FATHER'S NAME James	13b. MOTHER'S MAIDEN NAME Mary Walkin	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown	16. SOCIAL SECURITY NO. unknown	17. INFORMANT'S SIGNATURE OR NAME Records Jackson Co Hosp - Indep Mo	ADDRESS
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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		INTERVAL BETWEEN ONSET AND DEATH 36 hours
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Influenza		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) cerebral hemorrhage		
DUE TO (c)		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senile psychosis	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 331" X	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 10-9-, 1952, to 1-21-, 1953, that I last saw the deceased alive on 1-21, 1953, and that death occurred at 10:00 Pm., from the causes and on the date stated above.

22a. SIGNATURE Dr. C. Blumenschein (Degree or title) MD	23b. ADDRESS Heat. Co Independence	23c. DATE SIGNED 22 Jan 53
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 1-27-53	24c. NAME OF CEMETERY OR CREMATORY Mt Washington	24d. LOCATION (City, town, or county) (State) Kansas City Mo
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DATE REC'D BY LOCAL REG. 1-22-1953	REGISTRAR'S SIGNATURE D. B. Langford	483	25. FUNERAL DIRECTOR'S SIGNATURE Mr. C. L. Foster	ADDRESS 74 N. C. Mo
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(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

W. B. Rangeford

Student _____

Student Embalmer

Licensed Embalmer No. 3837

P. O. Address Leis Summit

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.