

STANDARD CERTIFICATE OF DEATH

State File No. 73

FILED FEB 7 - 1955

BIRTH NO. _____ REG. DIST. NO. 6 PRIMARY REG. DIST. NO. 5031 Registrar's No. 1

1. PLACE OF DEATH a. COUNTY <u>Audrain</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before institution). a. STATE <u>Missouri</u> b. COUNTY <u>Audrain</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural - Cuivre</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural - Cuivre</u>	
c. LENGTH OF STAY (In this place) <u>22 years</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>7 miles N. E. Wellsville</u>		d. STREET ADDRESS (If rural, give location) <u>7 miles N. E. Wellsville</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>MANN</u>	b. (Middle) <u>MORRIS</u>	c. (Last) <u>GROVER</u>	4. DATE OF DEATH (Month) (Day) (Year)
				<u>Jan. 23 1955</u>

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 29 1878</u>	9. AGE (In years last birthday) <u>76</u>	IF UNDER 1 YEAR	IF UNDER 24 HRS.
					Months <u>1</u> Days <u>25</u>	Hours <u></u> Mins. <u></u>

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>Albion, Nebraska</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>
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13a. FATHER'S NAME <u>James Grover</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Leach</u>	14. NAME OF HUSBAND OR WIFE <u>Mrs. Sadie Grover</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Dwight Leaver Wellsville Mo.</u>	ADDRESS <u>Wellsville 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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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"/>
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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) <u>Wellsville (Audrain) Mo.</u>
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? _____

22. I hereby certify that I attended the deceased from Jan 23 1955, to Jan 23 1955, that I last saw the deceased alive on Jan 23, 1955, and that death occurred at 11 P. M., from the cause and on the date stated above.

23a. SIGNATURE <u>Mallie H. Waller</u>	(Degree or title) _____	23b. ADDRESS <u>Wellsville Mo.</u>	23c. DATE SIGNED <u>1/26/55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>1/26/55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Wellsville Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Wellsville, Montg. Mo</u>
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DATE REC'D BY LOCAL REG. <u>Feb. 3 1955</u>	REGISTRAR'S SIGNATURE <u>Mallie Fuqua</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>H. B. Bell</u>	ADDRESS <u>Wellsville Mo</u>
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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 _____

working under my personal supervision.

Student Embalmer No. _____

Signed _____
Student Embalmer

Signed

A. B. Kelle

Licensed Embalmer No. _____

P. O. Address *Kelleville 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.