

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-022099

STATE FILE NUMBER

Health,  
& Welfare  
Public  
Service

FILED JUN 29 1959

Registration District No. 385- Primary Registration District No. 3039 Registrar's No. 52

S. 300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Linn</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Linn</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Marceline</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Marceline</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Florence Rest Home</b>		Length of stay in lb <b>3mo.</b>	d. STREET ADDRESS (If outside, give location) <b>221 E. Lake</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Harden</b> Last <b>Groce</b>			4. DATE OF DEATH Month <b>6</b> Day <b>9</b> Year <b>1959</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 3. WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>4/26/1886</b>	9. AGE (In years last birthday) <b>73</b> IF UNDER 1 YEAR Months <b>1</b> Days <b>13</b> IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	11. BIRTHPLACE (City and state or country) <b>Ethel, Mo</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>David</b>		13b. MOTHER'S MAIDEN NAME <b>Martha Brown</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 Address <b>Grethel Hatfield Ft. Madison, Iowa</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Tuberculosis and Pneumonia</b>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>emphysema, asthma, A.S.C.V.D.</b>					
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>Jan 1959</b> to <b>6-9-59</b> and last saw him alive on <b>6-6-59</b> Death occurred at <b>5:15</b> P m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>George J. [Signature]</b> (Degree or title)			22b. ADDRESS <b>Marceline Missouri</b>		22c. DATE SIGNED <b>6-11-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>B</b>		23b. DATE <b>6/12/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Union Chapel</b>		23d. LOCATION (City, town, or county) (State) <b>Ethel, Mo</b>
24. FUNERAL DIRECTOR <b>James McLaughlin Marceline, Mo</b>			25. DATE RECD. BY LOCAL REG. <b>6-12-59</b>	26. REGISTRAR'S SIGNATURE <b>Brookie Owens</b>	

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

300  
M.D.

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.

Student .....  
Signature of Student Embalmer

Signed *James B. McClelland* .....

Licensed Embalmer No. *4230* .....  
P. O. Address *Brookfield, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.