

OCT 18 1939
Registration District No. **399**

Primary Registration District No. **1002**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. WRITE LEGIBLY—USE UNFADING BLACK INK—MAKE A

1. PLACE OF DEATH:
(a) County Jackson, County
(b) City or town Hannas City, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution St. Joseph Hospital, Hannas City
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 weeks
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County 1
(c) City or town Lower
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Miss Carolyn Grier 160
3. (b) If veteran, name war No
3. (c) Social Security No. No

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 9 day 22
year 99 hour 11 minute 05 P.M.
21. I hereby certify that I attended the deceased from 8-12-39
_____, 19____, to 9-22-39, 19____;
and that death occurred on the date and hour stated above.
that I last saw her alive on 9-22-39, 19____;

4. Sex Female **5. Color or race** White
6. (a) Single, widowed, married, divorced, single
6. (b) Name of husband or wife _____ **6. (c) Age of husband or wife if** _____
alive _____ years
7. Birth date of deceased August 26 1914
(Month) (Day) (Year)

Immediate cause of death Generalized Peritonitis
Due to Perforation of Intestine - Illium
Due to Pelvic Peritonitis - organism not determined
Other conditions _____
(Include pregnancy within 3 months of death)
Major findings: Pelvic Peritonitis Chr
Hydrocephalus
Of autopsy as above
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

8. AGE: Years 25 Months 0 Days 26
If less than one day _____ hr. _____ min.

9. Birthplace Buchanan County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation clerk in store

11. Industry or business _____

MOTHER FATHER
12. Name R. C. Grier
13. Birthplace Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Lou Adamec
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature R. C. Grier
(b) Address Bower Mo

17. (a) Burial _____ **(b) Date thereof** 9/24/1939
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation New Harmony

18. (a) Signature of funeral director W. H. Sullivan
(b) Address Langer, Mo

19. (a) Date received local registrar Sept 22 1939 **(b)** M. D. Brown
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ **(e) Means of injury** _____
23. Signature Russell W. Brown (M. D. or other) _____
Address St. Louis **Date signed** _____

107

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.....

S. R. McComas....., Registered Apprentice No.....
working under my personal supervision.

Signed S. R. McComas

Licensed Embalmer No. 2303

P. O. Address Smithville, 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, above space should be left blank.

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

316047

1. PLACE OF DEATH

County Jackson
Township K.C.
City K.C.

Registration District No. 399
Primary Registration District No. 1202
(No. St. Joseph Hosp.)

File No. ~~24927~~
Registered No. 3702 -
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) D.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
25 0 26

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) _____ Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19____

19. UNDERTAKER (ADDRESS)

20. FILED 9/22, 1939 M. M. Jerome Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 22, 1939

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Peritonitis
Perforation intestinal
Pelvic peritonitis
regimen unknown
Other contributory causes of importance:
Hydrocephalus n.m.d.
Do not know cause

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____ If so, specify _____

(Signed) Russell Kerr, M. D.
(Address) K.C. Mo.

N. B.—Every item of information should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

TEMPORARY

