

No. 2
1-10-25
57
X21492

Registration District No. 213

Primary Registration District No. 5293

Registrar's No. 207

1. PLACE OF DEATH:

(a) County Cole **DEAD SEP 19 1940**

(b) City or town Taos, Mo. - Jefferson Twp
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
R.R. 4 Jefferon on City, Mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community 48 Years
years, months or days)

3. (a) PRINT FULL NAME Herman Grohoff 610

8. (b) If veteran, name war None 8. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Helen Kerperin 6. (c) Age of husband or wife if alive Dead years

7. Birth date of deceased December 22, 1850
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

90 7 20 hr. _____ min.

9. Birthplace Germany
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Otto Grothoff 6

{ 13. Birthplace Germany
(City, town, or county) (State or foreign country)

{ 14. Maiden name Mary Hemmersmeier

{ 15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Anton Grothoff

(b) Address Taos, Mo.

17. (a) Burial (b) Date thereof 8/16/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Taos, Mo.

18. (a) Signature of funeral director John J. Smith

(b) Address Jefferson City, Mo.

19. (a) 8/17/40 (b) W. R. ... M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cole

(c) City or town Taos, Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. R.R. 3 Jefferon City, Mo.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 12,
year 1940 hour 2 P. M. minute _____ M.

21. I hereby certify that I attended the deceased from July 1,
1940, to Aug 12, 1940;

that I last saw him alive on Aug 12, 1940, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertension
arteriosclerosis

Due to Ch. myocardial hypertension

Due to _____

Other conditions:
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? _____ (Specify type of place)

(e) Means of injury _____

23. Signature Learna Taylor (M. D. or other) M.D.

Address Jefferson City Date signed 8-15-40

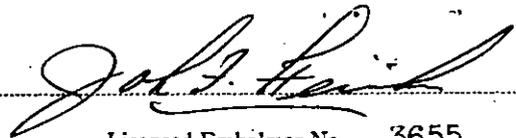
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

930

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....



Licensed Embalmer No..... 3655

P. O. Address..... Jefferson City, 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
STANDARD CERTIFICATE OF DEATH

State File No. **28334**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **213**

Primary Registration District No. **5293**

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Cole

(b) City or town Suffern, N. Y.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Herman Greshoff

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m 5. Color or race w

6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 90 Months 7 Days 20 If less than one day _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: month Aug day 17
year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: Hypostatic
Pneumonia - Bronchial
Ch. Myo Carditis
+ hypertension

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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? _____ (Specify type of place) _____ (e) Means of injury _____

23. Signature Dean A. Dayles (M. D. or other) _____
Address _____ Date signed 10-8-45

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

