

DEC 26 1941

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

43271

Do not use this space.

1. PLACE OF DEATH *Webster*  
 (a) County *Webster* Registration District No. *117*  
 (b) Township *York* Primary Registration District No. *117* Registered No. *117*  
 (c) City *York* (d) Street No. *0*  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *John Gross*  
 (a) Residence, No. *5* *County Farm* St.  (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *wh* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED *2 Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *No Record*

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<i>No Record</i>	<i>-</i>	<i>-</i>	<i>-</i>	

OCCUPATION

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *No Record* *9*

FATHER

13. NAME " "  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) " " *9*

MOTHER

15. MAIDEN NAME " "  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) " " *9*

17. INFORMANT (ADDRESS) *Glen King*  
*Supt. County Farm*

18. BURIAL, CREMATION OR REBURYAL  
 PLACE *Waukegan* DATE *Dec: 18 1941*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *W. Graham Funeral Director*  
*Waukegan*

20. FILED 19..... Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Dec 17 1940*

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 *8 P* m.

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

	Date of onset
<i>✓</i>	

Other contributory causes of importance:

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)....., M. D.  
 (Address).....

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**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.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to  
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. 43271

Registration District No. 896

Primary Registration District No. 6198

Registrar's No. ....

1. PLACE OF DEATH:

(a) County Wheeler

(b) City or town Rural  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of Hospital or Institution: Wheeler County Farm  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 20 years  
(Specify whether)

In this community life  
years, months or days)

3. (a) PRINT FULL NAME John Gross

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 w

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 Months Days 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) (Burial, cremation, or removal) (b) Date thereof. (Month) (Day) (Year)

(c) Place: burial or cremation.

18. (a) Signature of funeral director

(b) Address

19. (a) 3/19/1942 (b) J. Bruce  
(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) Citizen of foreign country? .... (Yes or No)  
If yes, name country. ....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day 14 year 1940 hour 10 minute 00 M.

21. I hereby certify that I attended the deceased from 19 to 19; that I first saw him live on and that death occurred on the date and hour stated above. Immediate cause of death.

Wheeler Pneumonia

Due to. ....  
Due to. ....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 108

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (c) Means of injury

23. Signature J. Bruce (M. D. or other)

Address Manfield Mo Date signed 3/19/42

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

MOTHER FATHER

USE PREVIOUS EDITIONS - MAKE A DEPARTMENT RECORD

S-43271