FILED AUG 24 1942

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

28409

Do not use this space.

107

1. PLACE OF DEATH (a) County Texas — Registration District No. 568 10
(b) Township or (c) City Boone Kindlepost — Primary Registration District No. 61500 — Registered No. Three
(d) Street No. ____ St.
(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 Ellsworth Grant Granger
(a) Residence, No. ____ 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: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married
5A. IF MARRIED, ~~WIDOWED, OR DIVORCED~~ HUSBAND OF (OR ~~WIFE OF~~) Laura Granger
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 26, 1864
7. AGE: Years 77 — Months 5 — Days 9 — If LESS than 1 day, ____ hrs. or 40 min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
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) Jan 1941
11. Total time (years) spent in this occupation 50

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not known this

FATHER
13. NAME George Granger
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not known " "

MOTHER
15. MAIDEN NAME Miss — Shafer
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not known " "

17. INFORMANT (ADDRESS) Roy Granger Kindlepost Mo

18. BURIAL, ~~CREMATION OR REMOVAL~~ PLACE Shafer Cem DATE 2-16 1942

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Smith & Ferguson Licking Mo

20. FILED 2-15 1942 [illegible] Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-15 1942

22. I HEREBY CERTIFY, That I attended deceased from Jan 10 1942 to 2-15 1942, that I last saw him alive on Feb 13 1942. Death is said to have occurred on the date stated above, at 4:00 A m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
acute nephritis	

Other contributory causes of importance: Bronchopneumonia

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? No
If so, specify ____
(Signed) Leslie Lindell, M. D.
(Address) Licking Mo

1231 (Licensed Embalmer's Statement on Reverse Side)

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.

PRINTED WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED
District Health Officer No. 5,
District File Number 742617
Date Filed 8-19-42

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 Not Embalmed, Registered Apprentice No. ..... working under my personal supervision.

Signed Eubert E Ferguson

Licensed Embalmer No. 3945

P. O. Address Licking Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

2B
1-41
Fo. X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28409

Registration District No. 868 Primary Registration District No. 6150 Registrar's No. 3

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

1. PLACE OF DEATH:

(a) County Texas

(b) City or town Rural
(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 years, months or days)

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

3. (a) PRINT FULL NAME

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept (Month) 26 (Day) 1865 (Year)

8. AGE: Years 77 Months 5 Days 9 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 15
year 1942 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 acute nephritis
Due to
Due to Bronchopneumonia

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

23. Signature Lulu Randall (M. D. or other)
Address Licking Mo Date signed

SUPPLEMENTARY