. S. No. 2
DM—5-42
ev. 5-17-39
X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 17 1944

Registration District No. 336

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25881

Primary Registration District No. 6130

Registrar's No. (6130)

1. PLACE OF DEATH

(a) County: Shannon

(b) City or town: Rural Jacks Twp
(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: 1 (Specify whether

In this community: years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Shannon 101

(c) City or town: Rural Jacks Twp
(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: Buck George

3. (b) If veteran, name war: —

3. (c) Social Security No.: —

4. Sex: M 0

5. Color or race: W

6. (a) Single, widowed, married, divorced: Widower

6. (b) Name of husband or wife: Amanda Gropp

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

7. Birth date of deceased: Jan (Month) 12 (Day) 1864 (Year)

8. AGE: Years 80 Months 5 Days 7 If less than one day hr. min.

9. Birthplace: (City, town, or county) Mo 11 (State or foreign country)

10. Usual occupation: Farmer

11. Industry or business:

FATHER
12. Name: James George
13. Birthplace: (City, town, or county) Tenn 1 (State or foreign country)

MOTHER
14. Maiden name: Amy Daniels
15. Birthplace: (City, town, or county) Tenn 1 (State or foreign country)

16. (a) Informant: Noel George

(b) Address: ~~Eu~~ Round Spring Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-20-44 (Month) (Day) (Year)

(c) Place: burial or cremation: Summers Cemetery

18. (a) Signature of funeral director: None

(b) Address: —

19. (a) 6-14-44 (Date received local registrar) (b) Frank Hyde MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 14 year 1944 hour 5 minute a M.

21. I hereby certify that I attended the deceased from ....., 19....., to ....., 19.....;

that I last saw h..... alive on ....., 19.....;

and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Chronic Bronchitis	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

106a

Major findings:
Of operations:

Of autopsy:

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: Frank Hyde (M. D. or other)

Address: Eunice Mo Date signed 6-14-44

(Licensed Embalmer's Statement on Reverse Side)

1944
86
7824

RECEIVED
District Health Officer No. 5,
District File Number 744409
Date Filed 7-14-44

1944 - 6 - 19
1864 - 1 - 12
80 2 - 7

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 comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.