S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUL 3 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23218

Registration District No. 371 Primary Registration District No. 6261 Registrar's No. 19

1. PLACE OF DEATH:
(a) County Webster
(b) City or town Rogersville, Rural (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: West Benton Twp. Home (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 Missouri (b) County Webster
(c) City or town Rogersville, Rural (If outside city or town limits, write "RURAL")
(d) Street No. ..... (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME Otto T. Grier
3. (b) If veteran, name war .....
3. (c) Social Security No. .....
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of ~~husband~~ or wife Hassah
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased Dec. (Month) 19 (Day) 1876 (Year)

8. AGE: Years	Months	Days	If less than one day
70	4	9	..... hr. ..... min.

9. Birthplace Greene (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Farmer
11. Industry or business John Grier
FATHER
12. Name Missouri
13. Birthplace Mollie Turner (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name .....
15. Birthplace Missouri (City, town, or county) (State or foreign country)
16. (a) Informant Brooks Grier
(b) Address Rogersville No R# 3
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof April 13-47 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~ Mt Olive Cem
18. (a) Signature of funeral director Kelley Terrell Bergman
(b) Address Rogersville Mo.
19. (a) June 26 1947 (Date received local registrar) (b) Lester G. Good (Registrar's signature) 2422

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month April day 10 year 1947 hour 5 minute 00 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.

	Duration
Immediate cause of death Cerebral Hemorrhage	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) 83A	
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 K. K. Kelley Coroner Webster Co (M. D. or other)
Address Fordland Mo Date signed 4-12-47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6
District File Number 647-689
Date Filed JUN 30 1947

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 K. K. Kelley

Licensed Embalmer No. 3334

P. O. Address Fordland 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, fact should be so stated above.