

FILED JUN 3 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16280

BIRTH NO. _____ REG. DIST. NO. 150 PRIMARY REG. DIST. NO. 5573 Registrar's No. 83

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN Grain Valley (Rural))		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Grain Valley - Rural Sni a bar	
c. LENGTH OF STAY (in this place) 10 yrs		d. STREET ADDRESS (If rural, give location) 1/2 mi East	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1/2 mi East			

3. NAME OF DECEASED (Type or Print) Archie L. Shroust			4. DATE OF DEATH (Month) (Day) (Year) May - 3 - 49		
5. SEX M		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married - 1	
8. DATE OF BIRTH Aug - 6 - 1889		9. AGE (In years last birthday) 59		10. KIND OF BUSINESS OR INDUSTRY Farmer	
11. BIRTHPLACE (State or foreign country) Grain Valley Mo		12. CITIZEN OF WHAT COUNTRY? U. S. A		13. MOTHER'S MAIDEN NAME Eddie Reid	
13a. FATHER'S NAME J. L. Shroust		14. NAME OF HUSBAND OR WIFE Goldie M		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) none	
16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Mrs Goldie Shroust		ADDRESS Grain Valley Mo	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Adenocarcinoma left testicle		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from July 13, 1946, to May 3, 1949, that I last saw the deceased alive on May 3, 1949, and that death occurred at 3 p. m., from the causes and on the date stated above.

23a. SIGNATURE Merrill R. Bay M.D.		(Degree or title)		23b. ADDRESS Blue Springs Mo.		23c. DATE SIGNED 5-4-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE May - 3 - 49		24c. NAME OF CEMETERY OR CREMATORY Blue Springs		24d. LOCATION (City, town, or county) (State) Blue Springs Mo	
DATE REC'D BY LOCAL REG. 5-5-49		REGISTRAR'S SIGNATURE Howard C. Earnshaw		578		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Mrs G B Webb & Son Blue Springs Mo	

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

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FEB 16 1961

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student

Student Embalmer

Signed

ROB Webb

Licensed Embalmer No. 2353

P. O. Address Blue Springs 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.