

THE DIVISION OF HEALTH OF IOWA
STANDARD CERTIFICATE OF DEATH

State File No. **38074**

FILED DEC 1 1952

BIRTH NO. _____ REG. DIST. NO. **47** PRIMARY REG. DIST. NO. **3016** Registrar's No. **291**

0264!

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

1. PLACE OF DEATH a. COUNTY Cole		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE IOWA b. COUNTY APPANOOSE	
b. CITY OR TOWN Jefferson City Mo.		c. CITY OR TOWN MOULTON	
c. LENGTH OF STAY (In this place) Mo. 1948		8140	
d. FULL NAME OF HOSPITAL OR INSTITUTION 985 West McLearty		d. STREET ADDRESS (If rural, give location) 8	

3. NAME OF DECEASED (Type or Print) John Thomas Groves Jr			4. DATE OF DEATH (Month) (Day) (Year) Nov 28-1952		
a. (First)		b. (Middle)		c. (Last)	

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH April 15 1861	9. AGE (In years last birthday) 91	IF UNDER 1 YEAR 7 Months	IF UNDER 1 YEAR 13 Days	IF UNDER 1 YEAR 13 Hours	IF UNDER 1 YEAR 13 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Basket Maker	10b. KIND OF BUSINESS OR INDUSTRY Basket Maker	11. BIRTHPLACE (City and State or Foreign Country) Fayette Ind.	12. CITIZEN OF WHAT COUNTRY? U.S.A
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13a. FATHER'S NAME John Thomas Groves	13b. MOTHER'S MAIDEN NAME Francis Busch	14. NAME OF HUSBAND OR WIFE _____
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME Mrs. Bennie Dawson ADDRESS Jefferson City Mo.
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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 10 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial failure		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Uremic Poisoning		
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"/>
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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) _____
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR _____
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22. I hereby certify that I attended the deceased from **10th Nov 1952** to **Nov. 28, 1952** that I last saw the deceased alive on **Nov 28, 1952** and that death occurred at **10:20 PM** from the causes and on the date stated above.

23a. SIGNATURE Leon B. Lake (Degree or title) _____	23b. ADDRESS Do Jefferson City Mo 11-28-52	23c. DATE SIGNED _____
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 11-30-52	24c. NAME OF CEMETERY OR CREMATORY Oakland	24d. LOCATION (City, town, or county) (State) Moulton Ia
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DATE REC'D BY LOCAL REG. Nov. 28-1952	REGISTRAR'S SIGNATURE R. P. Davis MD-MR.	25. FUNERAL DIRECTOR'S SIGNATURE EAGLE FUNERAL ADDRESS MOULTON IOWA
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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.....

Everett R Head

Student Embalmer No. *✓*

working under my personal supervision.

Student *✓*.....
Student Embalmer

Signed.....

Everett R Head

Licensed Embalmer No. *4038*

P. O. Address *Lancaster, 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.