

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23374**
Registrar's No. **657**

FILED JUL 23 1956

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2002</u>		Registrar's No. <u>657</u>	
1. PLACE OF DEATH a. COUNTY Greene				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). -a. STATE Missouri b. COUNTY Christian			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. LENGTH OF STAY (in this place) 2 Mos.		c. CITY OR TOWN Billings		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Mercy Infirmary				e. STREET ADDRESS (If rural, give location) No Street Address <u>0220</u>			
3. NAME OF DECEASED (Type or Print) a. (First) ELIZABETH			b. (Middle) MARGARET		c. (Last) GROVE		4. DATE OF DEATH (Month) (Day) (Year) July 15, 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	8. DATE OF BIRTH Jan. 26, 1866		9. AGE (In years last birthday) 90	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Dry Goods		11. BIRTHPLACE (City and State or Foreign Country) St. Charles Co., Mo.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Francis Grove			13b. MOTHER'S MAIDEN NAME Theresa Freymuth		14. NAME OF HUSBAND OR WIFE None		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Vernon Leitensorfer, Billings, 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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arterio-sclerotic Heart</u> INTERVAL BETWEEN ONSET AND DEATH _____ ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Dream</u> 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)		4200	
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			
22. I hereby certify that I attended the deceased from <u>7-17</u> , 19 <u>56</u> , to <u>7-15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7-15</u> , 19 <u>56</u> , and that death occurred at <u>6:00a.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>John H. D. Springfield, Mo.</u> (Deceased or title)				23b. ADDRESS		23c. DATE SIGNED 7-19-56	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 7/17/1956	24c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery		24d. LOCATION (City, town, or county) (State) Billings, Missouri		
DATE REC'D BY LOCAL REG. 7-19-56		REGISTRAR'S SIGNATURE <u>Edith Williamson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wear Harris</u>		ADDRESS Clever, Mo.	

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

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.....
Signature of Student Embalmer

Signed..... *W. Earl Harris*

Licensed Embalmer No. *4390*

P. O. Address..... *Cleveland, O.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.