

Health,
Welfare
Public
Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED SEP 16 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32798

STATE FILE NUMBER

Registration District No. 251 Primary Registration District No. 4975 Registrar's No. 284

1. PLACE OF DEATH a. COUNTY <u>NODAWAY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>NODAWAY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN <u>CONCEPTION Jct., Mo</u> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>CONCEPTION Jct</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) Length of stay in 1b HOSPITAL OR <u>1 BLK NORTH OF</u> INSTITUTION <u>CATHOLIC CHURCH LIFE</u>		d. STREET <u>1 BLK. NORTH OF</u> (If outside, give location) Reside on Farm ADDRESS <u>CATHOLIC CHURCH</u> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>LAURENCE PATRICK GROWNEY</u> First Middle Last			4. DATE OF DEATH <u>Sept 7 1957</u> Month Day Year				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHT</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 29, 1875</u>		9. AGE (In years last birthday) <u>81</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (City and state or country) <u>CONCEPTION Jct, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN GROWNEY</u>			14. MOTHER'S MAIDEN NAME <u>MARY FARNAN</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Katherine Maher</u> Address <u>Conception Jct, Mo.</u>			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arteriosclerosis and digitalis intoxication</u>		
DUE TO (c) <u>senility.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? <u>2</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE	

21. I attended the deceased from <u>Aug 7, 1953</u> to <u>Sept 7, 1957</u> and last saw her alive on <u>Sept 6, 1957</u> Death occurred at <u>10:50</u> A. m. on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <u>Clara K. Carlin MD</u>	22b. ADDRESS <u>Standberry, Mo.</u>	22c. DATE SIGNED <u>9-8-57</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Sept 9-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Columba Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Conception Mo.</u>
24. FUNERAL DIRECTOR <u>JOHNSON FUNERAL HOME,</u> ADDRESS <u>CONCEPTION Jct., Mo</u>		25. DATE RECD. BY LOCAL REG. <u>9-14-57</u>	26. REGISTRAR'S SIGNATURE <u>Bess Bolt</u>

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 *Ross Evan Johnson*

Licensed Embalmer No. *49*

P. O. Address *Stanberry*

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.