

# THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. **5781**

BIRTH NO. **FILED FEB 25 1954** REG. DIST. NO. **298** PRIMARY REG. DIST. NO. **4448** Registrar's No. **2**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Ray</b> b. CITY OR TOWN <b>LAWSON</b> c. LENGTH OF STAY (in this place) d. FULL NAME OF HOSPITAL OR INSTITUTION		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Ray</b> c. CITY OR TOWN <b>Lawson</b> d. STREET ADDRESS (If rural, give location)	
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<b>3. NAME OF DECEASED</b> (Type or Print) <b>SARAH</b>	a. (First) <b>SARAH</b>	b. (Middle) <b>MARTHA</b>	c. (Last) <b>GROSS</b>	<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>Feb 10 54</b>
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<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <b>never married</b>	<b>8. DATE OF BIRTH</b> <b>Feb. 20 1876</b>	<b>9. AGE</b> (In years last birthday) <b>77</b>	IF UNDER 1 YEAR Months <b>11</b> Days <b>20</b>	IF UNDER 1 HRS. Hours <b></b> Mins. <b></b>
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>at home</b>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>none</b>	<b>11. BIRTHPLACE</b> (City and State or Foreign Country) <b>Clay Co Mo</b>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>
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<b>13a. FATHER'S NAME</b> <b>Abraham Gross</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>Lucy Lalloon</b>	<b>14. NAME OF HUSBAND OR WIFE</b> <b>None</b>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or date of service) <b>no</b>	<b>16. SOCIAL SECURITY NO.</b> <b>none</b>	<b>17. INFORMANT'S SIGNATURE OR NAME</b> <b>Chas Gross</b>	<b>ADDRESS</b> <b>609 Karnon Blvd K.C. Mo</b>
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<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)	<b>MEDICAL CERTIFICATION</b> <b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)</b> <b>Cerebral Thrombosis acute</b> <b>ANTECEDENT CAUSES</b> *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. Asford conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis General</b> DUE TO (c)	<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 year</b>
<b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death.		

<b>19a. DATE OF OPERATION</b>	<b>19b. MAJOR FINDINGS OF OPERATION</b> <b>332 X</b>	<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)	<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b>
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<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) m.	<b>21e. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>21f. HOW DID INJURY OCCUR?</b>
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**22. I hereby certify that I attended the deceased from 2/10, 1954, to 2/10, 1954, that I last saw the deceased alive on 2/10, 1954, and that death occurred at 11:12 A.M., from the causes and on the date stated above.**

<b>23a. SIGNATURE</b> (Degree or title) <b>Reginald P. ...</b>	<b>23b. ADDRESS</b> <b>Ms. ...</b>	<b>23c. DATE SIGNED</b> <b>2/15/54</b>
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<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>24b. DATE</b> <b>2/15/54</b>	<b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>Lawson Cemetery</b>	<b>24d. LOCATION</b> (City, town, or county) (State) <b>Lawson Mo</b>
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<b>DATE RECD BY LOCAL REG.</b> <b>Feb 15 1954</b>	<b>REGISTRAR'S SIGNATURE</b> <b>Mrs. Raymond ...</b>	<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Carroll Prechard</b>	<b>ADDRESS</b> <b>Lawson Mo</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

No. 300  
10-48

**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 Louise K. Jarman

Licensed Embalmer No. 4589

P. O. Address Excelsior 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.