MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

2533

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1. PLACE OF DEATH
County Moniteau. Registration District No. 571 File No.
Township Walker Primary Registration District No. 5769 Registered No. 8
City ~~California, Mo.~~ (No. St. Ward)

2. FULL NAME John Fred Gross.
(a) Residence. (No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	Negro	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF Winnie Gross

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 15 1881

7. AGE			
47 YEARS	3 MONTHS	13 DAYS	If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Chicken Sticker
(b) General nature of industry, business, or establishment in which employed (or employer) Poultry Business
(c) Name of employer Claud Henderson.

9. BIRTHPLACE (CITY OR TOWN) Calisonnia
(STATE OR COUNTRY) Mo. Moniteau

PARENTS

10. NAME OF FATHER John A. Gross
11. BIRTHPLACE OF FATHER (CITY OR TOWN) La Grange
(STATE OR COUNTRY) Mo. Lewis Co.
12. MAIDEN NAME OF MOTHER Dianah Barber
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Cedar City
(STATE OR COUNTRY) Mo. Callaway Co.

14. INFORMANT Luella Thurston.
(Address) California Mo.

15. Filed Jan 30, 1929 Jacob Roth, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1 – 28 – 1929

17. I HEREBY CERTIFY, That I attended deceased from 1 – 27 – 1929, to 1 – 28 – 1929, that I last saw h[illegible] alive on 1 – 27 – 1929, and that death occurred, on the date stated above, at 5:30 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tuberculosis
2 M
L S A (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) F. K. Pope, M. D
1 – 29, 1929 (Address) California Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
City Cemetery	1-31 1929
20. UNDERTAKER L. D. Hardiman	ADDRESS J.C. Mo

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ... St. ..... Ward)

2. FULL NAME .....

(a) Residence. No..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.

I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19.....
that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos.....ds

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....mos.....ds

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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