

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

Do not use this space.

15007

**1. PLACE OF DEATH**

County Jackson Registration District No. 400 File No. ....  
 Township Prarie Primary Registration District No. 73570 Registered No. SP  
 City (No. ....) St. .... Ward)

**2. FULL NAME** John J. Griffith

(a) Residence. No. Jackson Quality House 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**

**MEDICAL CERTIFICATE OF DEATH**

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 1 - 1929

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

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1928 to 4-1, 1929  
 that I last saw him alive on 3-29, 1929, and that death occurred, on the date stated above, at 8 a.m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 4 - 1857  
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
72 # # # #

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Pneumonia

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work Gardener  
 (b) General nature of industry, business, or establishment in which employed (or employer) unknown  
 (c) Name of employer unknown

CONTRIBUTORY (SECONDARY) heart disease  
 (duration) yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH: \_\_\_\_\_

10. NAME OF FATHER unknown

18. WHERE WAS DISEASE CONTRACTED  
 DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

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

18. WHERE WAS DISEASE CONTRACTED  
 WAS THERE AN AUTOPSY? no

12. MAIDEN NAME OF MOTHER unknown

18. WHERE WAS DISEASE CONTRACTED  
 WHAT TEST CONFIRMED DIAGNOSIS clinical  
 (Signed) J. W. Green, M. D.  
4/1, 1929 (Address) Independence

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

\*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.

14. INFORMANT J. W. Hostetter  
 (Address) \_\_\_\_\_

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Western Dental College DATE OF BURIAL April 3 1929

15. H-3 29 J. S. James  
 FILED. REG. 19. REGISTRAR

20. UNDERTAKER No state funeral society ADDRESS K. O. Oles.  
Ketterlin.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should HAVE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

