

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

Do not use this space.

20974

File No. _____
Registered No. 60 _____
St. _____ Ward _____

1. PLACE OF DEATH

County Carroll Registration District No. 135
Township Carrollton Primary Registration District No. 3010
City Carrollton (No. _____) St. _____ Ward _____

2. FULL NAME

Rosamond Edwyrne Griffin

(a) Residence. No. Main 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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-1 1929

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

17. I HEREBY CERTIFY, That I attended deceased from 4/1/29 1929 to 6/1/29 1929 that I last saw h. alive on 6/1/29 1929 and that death occurred, on the date stated above, at 9:30 PM m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar. 8th 1911

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
18 2 24

Tumor on Brain
5:30

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. High School girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) Kansas City (STATE OR COUNTRY) Kans.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

10. NAME OF FATHER L. P. Griffin

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

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

WAS THERE AN AUTOPSY? Yes

12. MAIDEN NAME OF MOTHER Elmore Kiper

WHAT TEST CONFIRMED DIAGNOSIS

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

(Signed) H. B. Brown M. D.

14. INFORMANT L. P. Griffin (Address) Carrollton Mo

6/2 1929 (Address) Carrollton 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.

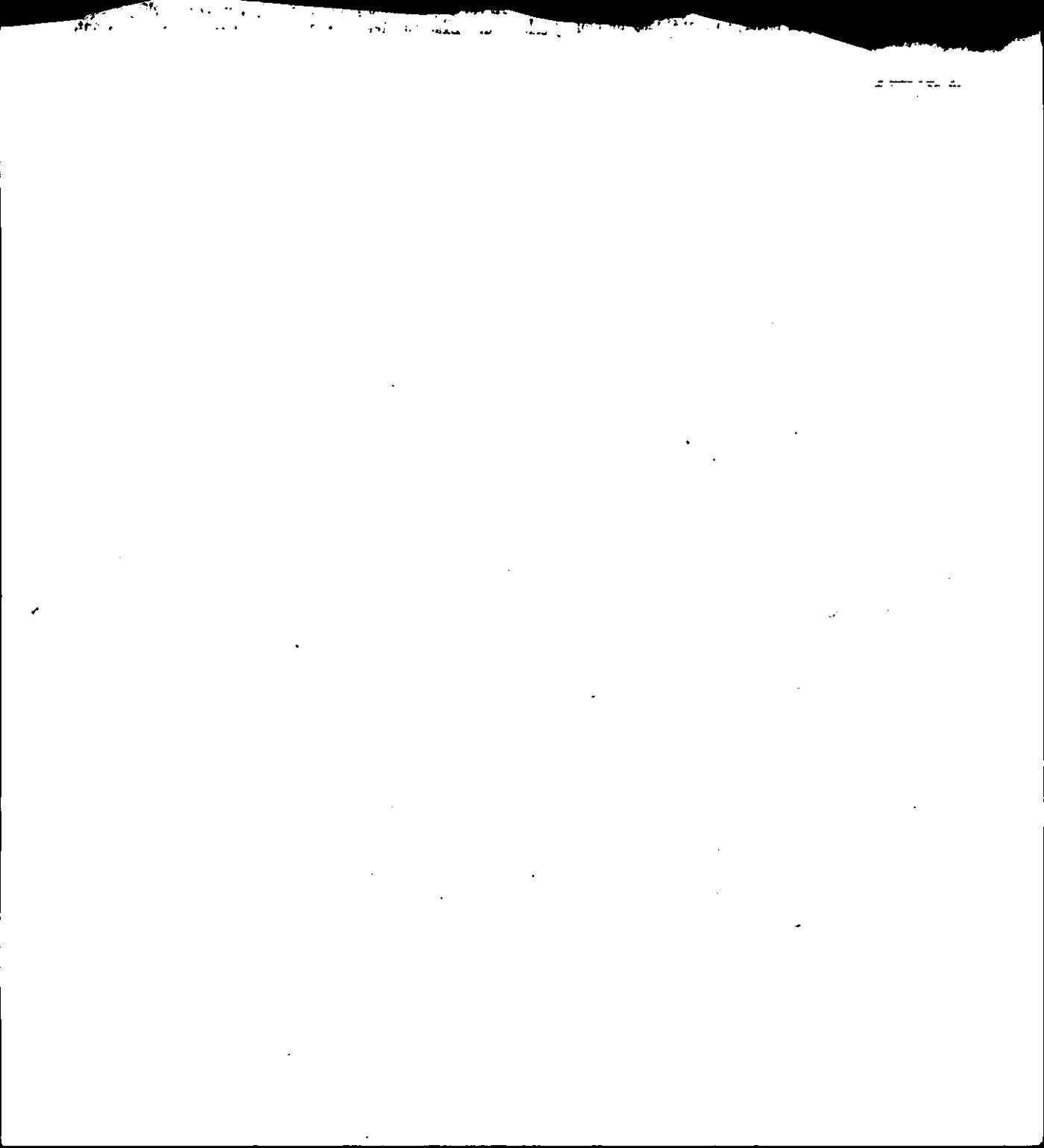
15. FILED 6/2 1929 Mrs. E. E. Farnham REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Oak Hill DATE OF BURIAL 6-3 1929

20. UNDERTAKER Standley Carrollton Mo. ADDRESS

Exact statement of OCCUPATION is very important. If any of these are classified. so that it may be properly classified.

26-1-2



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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Carroll
Township Carrollton
City Carrollton (No. St. Ward)

Registration District No. 135
Primary Registration District No. 2010

File No.
Registered No. 60

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.

Rosamond Edwyrne Griffin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S
(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)

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 6/2 1929 Mrs. E. E. Farwell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-1-29

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tumor on Brain
X was malignant
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

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) E. E. Farwell, 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. All 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. NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

49

1000