

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

Do not use this space.

7391  
7389

1. PLACE OF DEATH

County Shelby  
Township Jackson  
City (No. ....) (St. .... Ward)

Registration District No. 828  
Primary Registration District No. 6540

File No. ....  
Registered No. ....

2. FULL NAME

Samuel Allison Griffin

(a) Residence. No. .... St. ....  
(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)

Male Colored Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 13, 1922

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, .... hrs. or .... min.  
7 | 8 | 6

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at home  
(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) Shelby Co. Mo.

10. NAME OF FATHER Ben Griffin

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

12. MAIDEN NAME OF MOTHER Lotus Maulley

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

14. INFORMANT (Address) Ben Griffin  
Shelbyville Mo.

15. FILED Feb 19<sup>th</sup> 1930 Dr. C. T. White REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 19 - 1930

17. I HEREBY CERTIFY, That I attended deceased from Feb 19 1930 to Feb 19 1930 that I last saw him alive on Feb 19 1930, and that death occurred, on the date stated above, at 11:30 a. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

pneumonia (Bronch)  
107 R

(duration) .... yrs. .... mos. 3 ds.

CONTRIBUTORY (SECONDARY)

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH at home

DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? fluid test

(Signed) J. C. ...

, 19 (Address) Shelbyville, 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

O. O. F. Cemetery Feb. 20. 1930

20. UNDERTAKER J. W. Thompson Son ADDRESS Shelbyville, Mo.



**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 Shelby  
Township Jackson  
City (No. City) (St. Ward)

Registration District No. 828  
Primary Registration District No. 6040

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_

**2. FULL NAME**

Samuel Allison Griffin

(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**

**MEDICAL CERTIFICATE OF DEATH**

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/19 1930

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

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Pneumonia, Broncho  
following  
Whooping Cough  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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 \_\_\_\_\_

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

DID AN OPERATION PRECEDE DEATH \_\_\_\_\_ DATE OF \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.  
, 19 (Address)

9. BIRTHPLACE (CITY OR TOWN) (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.

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)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

19

14. INFORMANT (Address)

20. UNDERTAKER ADDRESS

15. FILED 4/10, 1930 D. C. T. White REGISTRAR

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW. CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact date of death.

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