

REC'D JUN 16 1938

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

18465

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 398
 (b) Township Blue Primary Registration District No. 5554 Registered No. 175
 (c) City Jackson City (d) Street No. 8828 Winner Rd. St.
 (e) Length of residence in city or town where death occurred 35 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

George W. Griffin
 (a) Residence, No. 8828 Winner Rd St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 31, 1873

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
64 9 8

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc. Steel worker
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

FATHER 13. NAME Carnuel Griffin

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

MOTHER 15. MAIDEN NAME Grayville

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

17. INFORMANT (ADDRESS) Lillie Flamm
907 G. 75th St

18. BURIAL, CREMATION, OR REMOVAL PLACE Memorial Park DATE June 11, 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Duane & Sons
Brush Creek + Gage

20. FILED 6-15-38 J. L. Cook
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 9, 1938

22. I HEREBY CERTIFY That I attended deceased from May 1st, 1938, to June 9, 1938.

I last saw him alive on June 8, 1938. Death is said to have occurred on the date stated above, at 520 A.M.

The principal cause of death and related causes of importance were as follows:

Carcinoma of face Date of onset

Other contributory causes of importance:
Myocardial Failure

Name of operation Date of

What test confirmed diagnosis: Biopsy Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? NO

If so, specify

(Signed) Paul G. Johnson, M. D.

(Address) 920 N. 1st

31A

52

THE BOARD OF EXAMINERS OF THE STATE OF ILLINOIS
DEPARTMENT OF HEALTH
BUREAU OF EMBALMERS

Central Hospital
930 Newton
Be 2572
1-5

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 _____

Registered Apprentice No. _____, working under my personal supervision.

Signed Nell Carr

Licensed Embalmer No. 3976

P. O. Address 1401 Brushcreek

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, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

18465-
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 398
 (b) Township Blue Primary Registration District No. 5854 Registered No. 17J
 (c) City _____ (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Geo. W. Griffin
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 9 1938

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

22. I HEREBY CERTIFY, That I attended deceased from 19____ to _____, 19____

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

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

The principal cause of death and related causes of importance were as follows:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
64 9 8

Carcinoma of face Date of onset

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

originally Buccal Area of cheek opposite 1st + 2nd upper Molars later involving entire

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

Other contributory causes of importance:
left cheek eroding into Mouth - Involving even Pharynx

FATHER 13. NAME

Name of operation _____ Date of _____
 What test confirmed diagnosis? Biopsy Was there an autopsy? _____

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

17. INFORMANT (ADDRESS)

Manner of injury _____
 Nature of injury _____

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____, 19____

19. FUNERAL DIRECTOR (ADDRESS)

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____

20. FILED _____, 19____

(Signed) Paula G. Johnson, M. D.
 (Address) 923 Newton

Local Registrar

PHYSICIANS SHOULD STATE EXACTLY OCCUPATION IS VERY IMPORTANT
 Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS SHOULD STATE EXACTLY OCCUPATION IS VERY IMPORTANT
 CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION IS VERY IMPORTANT
 PHYSICIANS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW

