DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 36716

Registration District No. 582 Primary Registration District No. 5779 Registrar's No. 37

1. PLACE OF DEATH: 3

(a) County Monroe

(b) ~~City or town~~ Rural Jackson

(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: County Home

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 months (Specify whether

In this community 2 months years, months or days)

2. USUAL RESIDENCE OF DECEASED: 1

(a) State Mo. (b) County Monroe

(c) City or town Monroe City

(If outside city or town limits, write "RURAL")

(d) Street No. Unknown

(If rural, give location)

(e) If foreign born, how long in U. S. A.? ✓ years.

3. (a) PRINT FULL NAME SUELL GRIFFITH 613

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Not Known

6. (b) Name of husband or wife Not Known

6. (c) Age of husband or wife if alive ✓ years

7. Birth date of deceased Not Known — (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
76	✓	✓	✓ hr. ✓ min.

9. Birthplace Unknown (City, town, or county) ✓ (State or foreign country)

10. Usual occupation None

11. Industry or business ✓

FATHER
12. Name Unknown
13. Birthplace " (City, town, or county) ✓ (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace " (City, town, or county) ✓ (State or foreign country)

16. (a) Informant's own signature Infirmary Records

(b) Address Paris, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 29, 1939 (Month) (Day) (Year)

(c) Place: burial or cremation County Home

18. (a) Signature of funeral director None

(b) Address ~~Paris, Missouri~~ 916

19. (a) 10-29-39 (Date received local registrar) (b) J. A. Barnett, M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 29th year 1939 hour 6:30 minute A. M.

21. I hereby certify that I attended the deceased from Oct 23 Oct 24 1939 to 1939 that I last saw him alive on Oct 24 1939 and that death occurred on the date and hour stated above.

Immediate cause of death Dysentery — Duration 1 Days

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature Geo M. Kaggle (M. D. or other)

Address Paris, Mo. Date signed 10-29-39

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

Rev. 5-17-39 I X19511

RECEIVED
District Health Officer No. 10
District File Number 11-39-1917
Date Filed NOV 14 1939

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.....

Licensed Embalmer No.....

P. O. Address.....

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.