

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 19347
Registrar's No. 57

District No. 744

Primary Registration District No. 3025 5976B

1. CAUSE OF DEATH
 City Ray
 County MO
 City or town Richmond, RFD
 Name of hospital or institution: none
 (If not in hospital or institution, write street number or location)
 Length of stay: In hospital or institution _____ (Specify whether _____)
 Community all of life -
 (months or days) 615

2. USUAL RESIDENCE OF DECEASED
 (a) State Mo. (b) County Ray
 (c) City or town Richmond, Mo RFD
 (If outside city or town limits, write "RURAL")
 (d) Street No. R 78
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

(a) PRINT FULL NAME Norma June Griffing
 (b) If veteran, name war _____
 (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month June day 4
 year 1940 hour 12 minute 0 M.
 21. I hereby certify that I attended the deceased from June 3 - 1940 to June 4 - 1940
 that I last saw her alive on June 3 - 1940
 and that death occurred on the date and hour stated above.

Sex Female 5. Color or race W. 6. (a) Single, widowed, married, divorced Single
 (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 Birth date of deceased June 30, 1940
 (Month) (Day) (Year)

Immediate cause of death
Acute Dilatation of Heart
Due to Valvular Deficiency
ATK 157C
 Other condition (Include pregnancy within 3 months of death)
Severe Vomiting

AGE:	Years	Months	Days	If less than one day
	<u>0</u>	<u>0</u>	<u>0</u>	<u>1</u> hr. <u>0</u> min.

Place of birth Richmond, Mo R.F.D.
 (City, town, or county) (State or foreign country)
 Usual occupation _____
 Industry or business _____

Major findings:
 Of operations _____
 Of autopsy _____
 Underline the cause to which death should be charged statistically.

Name Arnold Griffing
 Birthplace Richmond, Mo
 (City, town, county) (State or foreign country)
 Maiden name Leveta Cox
 Birthplace Richmond, Mo
 (City, town, or county) (State or foreign country)
 Informant Arnold Griffing
 Address Richmond, Mo. RFD

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? _____
 While at work? _____ (Specify type of place)
 Means of injury _____
 23. Signature G. B. Day (M. D. or other)
 Address Richmond Date signed June 4

(b) Date thereof June 4, 1940
 (Month) (Day) (Year)
 (c) Place: burial or cremation Lockery cemetery
 18. (a) Signature of funeral director Family 965
 (b) Address _____
 19. (a) June 4 - 40 (b) Malcol Jackson
 (Date received local registrar) (Registrar's signature)

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH

(a) County _____
 (b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
 (c) City or town _____
(If outside city or town limits, write "Rt.
 (d) Street No. _____
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____

3 (a) PRINT FULL NAME _____

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex _____ 5. Color or race _____ 6. (a) Single, widowed, married, divorced _____
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased _____
(Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
 18. Birthplace _____
(City, town, or county) (State or foreign country)
 14. Maiden name _____
 15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____
 year _____ hour _____ minute _____

21. I hereby certify that I attended the deceased from _____, 19____, to _____

that I last saw h _____ alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(include pregnancy within 6 months of death)

Major findings: _____
 Of operations _____
 Of autopsy _____

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)
 (d) Did injury occur in or about home, on farm, in industrial place, in public _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

RECEIVED
 District Health Officer No. 8
 District File Number
 Date Filed