

STANDARD CERTIFICATE OF DEATH

Registration District No. 7845

Primary Registration District No. 200

Registrar's No. 1182

1. PLACE OF DEATH:

(a) County St. Louis County  
(b) City or town Jefferson Barracks  
(c) Name of hospital or institution: Veterans Administration Facility  
(d) Length of stay: In hospital or institution Admitted 6/19/40  
In this community - years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County -  
(c) City or town Cartersville  
(d) Street No. 803 Fair Street  
(e) If foreign born, how long in U. S. A. - years.

3. (a) PRINT FULL NAME James W. Griffith

(b) If veteran, name war World War (c) Social Security No. 354-09-7151

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

(b) Name of husband or wife - 6. (c) Age of husband or wife if alive - years

7. Birth date of deceased June 14 1889

8. AGE: Years 55 Months 0 Days 0 If less than one day 0 hr. 0 min. 0

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

10. Usual occupation Laborer

11. Industry or business

12. Name Unavailable J. J. Griffith  
13. Birthplace Unavailable England  
14. Maiden name Unavailable Amanda Priddy  
15. Birthplace Unavailable Cartersville Ill.

16. (a) Informant M. Schullig

(b) Address Clinical Clerk, VAF, Jeff. Bks., Mo.

17. (a) Removal (b) Date thereof 6-22-40

(c) Place: burial or cremation Cartersville, Ill.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) JUN 22 1940 (b) C. W. Hughes, M.D. (Registrar's signature)

(Date received local registrar) (Date signed)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 21, year 1940 hour 8:10 minute 2 A.M.

21. I hereby certify that I attended the deceased from June 19, 19 40, to June 21, 19 40, that I last saw him alive on June 21, 19 40 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary arteriosclerotic heart disease, with cardiac enlargement, myocardial damage, anginal syndrome and severe myocardial insufficiency.

Other conditions None. (Include pregnancy within 3 months of death)

Major findings: Of operations - Of autopsy No autopsy.

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

(a) Accident, suicide, or homicide (specify) NO  
(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?  
(e) Means of injury While at work?  
23. Signature C. W. HUGHES, M.D. (M. D. or other)  
Address M.O.C. Date signed -

Duration Unkn.  
PHYSICIAN -  
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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

*Guy W W Wilkerson*

Licensed Embalmer No. 3575

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.