

164-13-40
17-39
X23159

Registration District No. 839

Primary Registration District No. 6101

1. PLACE OF DEATH: Stoddard
(a) County Stoddard
(b) City or town Rural - Richland Twp
(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
In this community years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Mississippi 6?
(c) City or town Charleston 2
(If outside city or town limits, write "RURAL")
(d) Street No. 603 W. Pecan 0
(If rural, give location)
(e) If foreign born, how long in U. S. A? years.

3. (a) PRINT FULL NAME JAMES GRIFFIN
3. (b) If veteran, name war No
3. (c) Social Security No. No

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan day 20
year 1941 hour minute M.

4. Sex MALE
5. Color or race Col
6. (a) Single, widowed, married divorced Married
6. (b) Name of husband or wife Resla Griffin
6. (c) Age of husband or wife if alive 24 years
7. Birth date of deceased Aug 3, 1910
(Month) (Day) (Year)

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

8. AGE: Years 30 Months 5 Days 17
If less than one day hr. min.

Immediate cause of death Basal Skull Fracture
suffered in auto accident
near Trailback, Stoddard
County, Missouri
Due to Crushed chest
(Include pregnancy within 3 months of death)

9. Birthplace Arkansas
(City, town, or county) (State or foreign country)
10. Usual occupation Farm Laborer
11. Industry or business Farming

Other conditions Crushed chest
(Include pregnancy within 3 months of death)

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

Major findings: Of operations none
Of autopsy none
PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant Resla Griffin
(b) Address 603 W. Pecan, Charleston Mo
17. (a) Burial (b) Date thereof 1-21-1941
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Oak Grove - Charleston Mo
18. (a) Signature of funeral director L. J. J. J.
(b) Address Charleston Mo
19. (a) 2-1-41 (b) J. P. Brandon
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following;
(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence 1-20-1941
(c) Where did injury occur? Trailback, Stoddard Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Yes Public Place
(Specify type of place)
While at work no (e) Means of injury Auto Wheel
23. Signature P. S. J. J. Acting Coroner
Address Bloomfield Mo. Date signed 1-30-41

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

170 C
98

RECEIVED

District Health Officer No. 2

District File Number 241-268

Case Filed 2/17/41-9

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, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 4608

Registration District No. 839

Primary Registration District No. 6101

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Stoddard
(b) City or town Richland T.P.
(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 _____ (Specify whether _____ years, months or days)

3. (a) PRINT FULL NAME James Griffin

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 30 Months 5 Days 17 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. 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 _____ (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)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Jan day 20 year 1941 hour _____ minute _____ M.

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

Immediate cause of death Basal skull fracture suffered in auto accident

Due to Was no collision--truck turned over by missing a bridge--county
Due to road--road not maintained by State.

Other conditions crushed chest
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy Truck turned over--crushed to death underneath same

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

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

(b) Date of occurrence 1-20-1941

(c) Where did injury occur? Tralbesse mo (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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

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

PHYSICIAN

Underline the cause to which death should be charged statistically.

