

JAN 30 1943

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 295

1. PLACE OF DEATH:

(a) County Jackson  
 (b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Wesley Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 6 hours  
(Specify whether years, months or days)  
 In this community 5 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
 (c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 516 East 27th St. Terrace  
(If rural, give location)  
 (e) Citizen of foreign country? ..... (Yes or No)  
 If yes, name country 0

3. (a) PRINT FULL NAME GEORGE FRANKLIN GRIFFIN

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single  
 6. (b) Name of husband or wife ..... 6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased November 29, 1937  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>5</u>	<u>1</u>	<u>20</u>	hr. min.

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

10. Usual occupation None

11. Industry or business

MOTHER FATHER { 12. Name George Griffin  
 13. Birthplace Kansas  
(City, town, or county) (State or foreign country)  
 14. Maiden name Mary Pocks  
 15. Birthplace Kansas City Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant George Griffin  
 (b) Address 516 East 27th St. Terrace

17. (a) Burial (b) Date thereof 1/21/1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sarat Hill Cemetery

18. (a) Signature of funeral director W. R. Brown  
 (b) Address 20 West Linwood

19. (a) 1-20-43 (b) W. R. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 19th  
 year 1943 hour 12: minute 30 AM.

21. I hereby certify that I attended the deceased from Pathologist 19..... to..... 19.....  
 that I last saw h..... alive on..... 19.....  
 and that death occurred on the date and hour stated above.

Immediate cause of death Streptococci sore throat

Due to 11/21/37

Other conditions Bronchopneumonia 1 day  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations .....  
 Of autopsy as above

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) (e) Means of injury

23. Signature Maurice L. Jones (M. D. certifying)  
 Address 909 Argyle Bldg Date signed 1-19-43

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

48  
30

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

**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 Charles M. Durk

Licensed Embalmer No. 3774

P. O. Address H. C. Mo

**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:**