

No. 2
5-17-39
X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 22078

Registration District No. 254

Primary Registration District No. 5867

Registrar's No.

1. PLACE OF DEATH:

(a) County Oregon

(b) City or town Thayer Twsp.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 90 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Oregon 75

(c) City or town Thayer (Rural)
(If outside city or town limits, write "RURAL") 0

(d) Street No. _____ (If rural, give location) 0

(e) Citizen of foreign country? _____ (Yes or No) 0
If yes, name country _____ 0

3. (a) PRINT FULL NAME George Calvin Griffin

3. (b) If veteran, name war --

3. (c) Social Security No. 429-36-3552

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 23
year 1943 hour 7 minute 3 P. 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.

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Euda Reola Wales

6. (c) Age of husband or wife if alive 20 years

7. Birth date of deceased Sept. 16 1919
(Month) (Day) (Year)

Immediate cause of death Internal Injury

8. AGE:	Years	Months	Days	If less than one day
	<u>23</u>	<u>8</u>	<u>7</u>	hr. _____ min.

Due to Fall from tree

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

10. Usual occupation Laborer

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

11. Industry or business _____

12. Name W. W. Griffin

13. Birthplace Tennessee
(City, town, or county) (State or foreign country)

14. Maiden name Liddie Grooms

15. Birthplace Oregon County Missouri
(City, town, or county) (State or foreign country)

Major findings: Of operations _____

Of autopsy no

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant W. W. Griffin

(b) Address Mammoth Spring, Ark.

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

(a) Accident, suicide, or homicide (specify) Accident 075

(b) Date of occurrence 5-23-1943

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

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

17. (a) (Burial, cremation, or removal) Burial (b) Date thereof 5/26/43
(Month) (Day) (Year)

(c) Place: burial or cremation New Salem Cem.

18. (a) Signature of funeral director Leo Carr

(b) Address Thayer, Mo.

While at work? _____ (Specify type of place)

(c) Means of injury _____

23. Signature Leo Carr (M. D. or other) Cornu

Address Thayer Date signed Mo.

19. (a) 6-12-43 (b) Jaell Williams
(Date received local registrar) (Registrar's signature)

RECEIVED
District Health Officer No. 5,
District File Number 44842^W
Date Filed 5-9-43

JUN 24 1950

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1111
Registrar's No. 111

Registration District No. 254 Primary Registration District No. 0-867

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

1. PLACE OF DEATH:
(a) County Oregon
(b) City or town Hayward, Calif.
(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 George C. Shuffin
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 M
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 23 Months 8 Days _____ If less than one day _____ min.
9. Birthplace _____ (City, town, or county) (State or foreign country) Mo.

10. Usual occupation _____
11. Industry or business _____
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) Joe W. Williams (Registrar's signature)
(Date received local registrar)

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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 23
year 1943 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 _____

Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____
Duration _____
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?
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTAL

S-22078