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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 19 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **2144**
Registrar's No. **53**

Registration District No. **114** Primary Registration District No. **4188**

WRITE PLAINLY - USE UNFADING BLACK INK - MAKE A PERMANENT RECORD
36
4
0

1. PLACE OF DEATH:
(a) County **Franklin**
(b) City or town **Sullivan.**
(c) Name of hospital or institution: **At home**
(If not in hospital or institution, write street number or location) **1**
(d) Length of stay: In hospital or institution..... (Specify whether)
In this community **All her life** years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri,** (b) County **Franklin** **36**
(c) City or town **Sullivan,** (If outside city or town limits, write "RURAL") **4**
(d) Street No. (If rural, give location) **0**
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **7**

3. (a) PRINT FULL NAME **Ethel Martin Griswold**
3. (b) If veteran, name war. (c) Social Security No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Dec.** day **31st.** year **1944** hour **10** minute **P.** M.
21. I hereby certify that I attended the deceased from **1944 Dec 31** to **1944 Dec 31**
that I last saw her alive on **Dec. 31** and that death occurred on the date and hour stated above.

4. Sex **Female** 5. Color or race **W**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Earl F. Griswold**
6. (c) Age of husband or wife if alive **50** years
7. Birth date of deceased **Nov. 6th. 1894**
(Month) (Day) (Year)

Immediate cause of death **Progressive Paralysis.**
Duration

8. AGE: Years Months Days If less than one day
50 **I** **25** hr. min.

Due to

9. Birthplace **Sullivan, Mo.** (City, town, or county) (State or foreign country)

Due to

10. Usual occupation **At Home**

Other conditions (Include pregnancy within 3 months of death) **830**

11. Industry or business

Major findings: Of operations

12. Name **Jos. J. Martin**

Of autopsy

13. Birthplace **Sullivan, Mo.** (City, town, or county) (State or foreign country)

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

14. Maiden name **Fannie Clymer.** (City, town, or county) (State or foreign country)

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

16. (a) Informant **Earl F. Griswold**
(b) Address **Sullivan, Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **1-3-1945** (Month) (Day) (Year)
(c) Place: burial or cremation **Sullivan, Mo.**

18. (a) Signature of funeral director **J. T. Williams**
(b) Address **Sullivan, Mo.**

19. (a) **Jan 3 1945** (Date received local registrar) (b) **Herbert Williams** (Registrar's signature)

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) (b) Means of injury **ind.**

23. Signature **Herbert Williams** (M. D. or other) Address Date signed

1121

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 1-17-45

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 J. T. Williams

Licensed Embalmer No. 427

P. O. Address Sullivan, 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.