V. S. No. 2
00M—5-43
ev. 5-17-39
o I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 3 1945

Registration District No. 199

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 5167

Primary Registration District No. 1002

Registrar's No. 797

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:
Osteopathic Hospital O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 Days (Specify whether
In this community 7 Years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson 48

(c) City or town: Independence 5
(If outside city or town limits, write "RURAL")

(d) Street No.: 109 East Lexington 8
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country: O

3. (a) PRINT FULL NAME: GOMER GARFIELD GRIFFITHS

3. (b) If veteran, name war: no

3. (c) Social Security No.: none

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Divorced

6. (b) Name of husband or wife: Unknown

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

7. Birth date of deceased: December 4th, 1871 (Month) (Day) (Year)

8. AGE: Years 73 | Months 12 | Days 27 | If less than one day ____ hr. ____ min.

9. Birthplace: Higbee, (City, town, or county) Missouri O (State or foreign country)

10. Usual occupation: Restaurant Operator

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Dorothy Cummings
(b) Address: Taylorville, Illinois

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/16/45 (Month) (Day) (Year)
(c) Place: burial or cremation: Taylorville, Illinois

18. (a) Signature of funeral director: Roland R. Speaks
(b) Address: Independence, Missouri

19. (a) 2-17-45 (Date received local registrar) (b) D. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 15
year 1945 hour 9 minute 37 A.M.

21. I hereby certify that I attended the deceased from 13 days
2-7, 1945 to 2/15/45, 19__;
that I last saw him alive on 2/15/45, 19__;
and that death occurred on the date and hour stated above.

Immediate cause of death: Rupture of
Denitrus Urinary of bladder

Due to: Hypertrophy of prostate

Due to: 137 Ca.

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

Major findings:
Of operations: Hypertrophy of prostate

Of autopsy: Ruptured diverticulum of the bladder

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature: G. G. Chouinard D.O. (M. D. or other)

Address: 112 Harrison Date signed 2/15/45

(Licensed Embalmer's Statement on Reverse Side)

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 John P. Sheil

Licensed Embalmer No. 3625

P. O. Address K 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.