

25699

State File No. _____

FILED SEP 14 1945

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 7791

1. PLACE OF DEATH:

(a) County _____

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

(c) Name of hospital or institution:
St. Johns Hospital.
(If not in hospital or institution, write street number or location)

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

In this community _____ ?
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 1438a Montgomery St.
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Fannie L. Griffiths

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Frank Griffiths

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

7. Birth date of deceased September 10, 1866
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>78</u>	<u>11</u>	<u>22</u>	hr. _____ min. _____

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

10. Usual occupation Housework

MOTHER FATHER

11. Industry or business _____

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. Ruth Fawcett

(b) Address 4280a Sacramento Ave.

17. (a) Burial (b) Date thereof Sept. 6, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Johns Cemetery

18. (a) Signature of funeral director Calvin F. Feutz Funeral Home
(Specify type of place)

(b) Address 4828 Natural Bridge Blvd.

19. (a) SEP 5 1945 (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 2nd, year 1945 hour 6:25 minute _____ P. _____ M. _____

21. I hereby certify that I attended the deceased from Aug 31 1945 to Sept 2 1945
 that I last saw him alive on 6-2-45 19____; and that death occurred on the date and hour stated above.

Immediate cause of death mesenteric thrombosis

Due to _____

Due to _____

Other conditions 44
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____

Of autopsy mesenteric thrombosis

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? _____ (c) Means of injury _____

23. Signature E. H. Bowler (M. D. or other) _____
 Address 634 N. Grand Date signed 9-8-45

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

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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 A. Glesner*

Licensed Embalmer No. *4186*

P. O. Address *St. Louis 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.