

FILED OCT 29 1945

Registration District No. 19 Primary Registration District No. 4164

Registrar's No.

1. PLACE OF DEATH:

(a) County De Kalb

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

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

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community life
years, months or days

3. (a) PRINT FULL NAME Roy Lee Griffin

3. (b) If veteran, name war _____

3. (c) Social Security 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 May 23 1941
(Month) (Day) (Year)

8. AGE: Years _____ Months 4 Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Clarksdale (City, town, or county) (State or foreign country) MS

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name Lee J. Griffin

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

14. Maiden name Rose Mary Thornton

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

16. (a) Informant Lee Griffin

(b) Address Maysville

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 3-45 (Month) (Day) (Year)

(c) Place: burial or cremation mt. Pleasant

18. (a) Signature of funeral director Wm. J. Brown

(b) Address Maysville Miss.

19. (a) _____ (b) Roscoe Davidson (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County De Kalb 37

(c) City or town 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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 2
year 1945 hour 8 minute _____ 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.

Immediate cause of death Accidental (supercar)

Due to _____

Due to _____

Other conditions (Include pregnancy within 5 months of death) _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings: _____
Of operations _____

Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

22. If death was due to external causes, including: _____

(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 0

23. Signature Dr. S. Gale (M. D. or other) _____
Address O. S. Barton Date signed _____

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

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 G. Brown

Licensed Embalmer No. *3933*

P. O. Address.....

Wayville, N.C.

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. Nov

Registration District No. 99

Primary Registration District No. 4/68

Registrar's No. _____

1. PLACE OF DEATH:

(a) County De Kalb
(b) City or town Maysville
(If outside city or town limits, write "RURAL" and name of township)
(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

Roy L. Griffin

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 _____

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

7. Birth date of deceased May 23 1945
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER { 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) _____ (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 _____ Day _____ Year 1985 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ after noon _____, 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 _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) Accidental

(b) Date of occurrence OCT-3-1985

(c) Where did injury occur? Myrtle Hill Road, De Kalb Co, Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? In home bet. Smith's

While at work? no (Specify type of place) (e) Means of injury Smothered

23. Signature M. S. Gile (M. D. or other) _____

Address O. S. Box 17, Mo Date signed 10/30/85

SUPPLEMENTARY

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

33643