

No. 2
1-43
17-39
K 56871

FILED JAN 16 1947

Registration District No. 150

Primary Registration District No. 5574

Registrar's No. 2

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Stone Jack (Rural) VAN BUREN
(If outside city or town limits, write "RURAL" and name of township) Twp

(c) Name of hospital or institution:
Rural Route One LONE JACK
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 months (Specify whether years, months or days)

In this community 4 months

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Rural Route One (Rural)
(If outside city or town limits, write "RURAL")

(d) Street No. Rural Route One
(If rural, give location)

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

3. (a) PRINT FULL NAME Earl De Las Griffiths

(b) If veteran, name war World War One

(c) Social Security No. 478-10-6325

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jun day 4
year 1947 hour 7 minute 150 M.

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Marble 6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased Sept 10 1892
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Sept 24, 1947 to Jun 4, 1947
that I last saw him alive on Jun 3, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Removal of lung Duration _____

8. AGE: Years 54 Months 9 Days 6 If less than one day hr. _____ min. _____

Due to Carcinoma

Due to _____

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

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

Major findings: _____

Of operations None

10. Usual occupation Salesman

PHYSICIAN

Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTAL INFORMATION REQUESTED

11. Industry or business _____

MOTHER FATHER

12. Name Thomas Griffiths

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

14. Maiden name Unknown Gages

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

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 E. J. Stoffer (M. D. or other) M.D.
Address 322 Thickett K.emo Date signed 1-4-47

16. (a) Informant Marble Griffiths

(b) Address Stone Jack, Mo.

17. (a) Removal (b) Date thereof 1-6-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Big Springs Four

18. (a) Signature of funeral director W. C. Carson

(b) Address Indeys Mo.

19. (a) JAN 4, 1947 (b) Harold C. Zinsbauer
(Date received local registrar) (Registrar's signature)

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

AUG 2 1949

FEB 3 1947

FEB 10 1947

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 *Floyd Labawson*

Licensed Embalmer No. *24199*

P. O. Address *Independence*

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. Let

Registration District No. 150

Primary Registration District No. 5574

Registrar's No. 2

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Rural
(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

2. USUAL RESIDENCE OF DECEASED:
 (a) City or town _____
(If outside city or town limits, write "RURAL")
 (b) County _____
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Evans O. Griffith
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month _____ Day _____
 Year 1947 Hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ 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 _____

4. Sex m
 5. Color or race w
 6. (a) Single, widowed, married, divorced _____
 6. (c) Age of husband or wife if alive _____ years _____ days

Duration _____
 Due to metastasis from lung carcinoma of lungs.

8. AGE: Years 54 Months _____ Days _____
If less than one day
 hr. _____ min. _____

Other conditions _____
(Include pregnancy within 3 months of death)
 Major findings: Of operations _____
 Of autopsy _____

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

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 E. S. Steiner (M. D. or other) _____
 Address 322 Shubert K. Mo Date signed 1-20-47

16. (a) Informant _____
 (b) Address _____
 17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation _____
 18. (a) Signature of funeral director _____
 (b) Address _____
 19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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

SUPPLEMENTARY

MOTHER FATHER

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

S-1461