

S. No. 2
 OM-5-43
 v. 5-17-39
 I X36671

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH
 1003

State File No. **18880**

Registration District No. **FILED JUN 31 1947**

Primary Registration District No. _____

Registrar's No. **5574**

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Lutheran Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 Weeks
(Specify whether
 In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County 000
 (c) City or town St. Louis Mo 17
(If outside city or town limits, write "RURAL")
 (d) Street No. 5823 Cabanne Ave. 9
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

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

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month June day 4
 year 1947 hour 3 minute 00 P.M.

4. Sex Female / 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 (Day) (Year)

21. I hereby certify that I attended the deceased from 5-13-1947 to June 4-1947
 that I last saw her alive on June 4-1947 and that death occurred on the date and hour stated above.
 Immediate cause of death: Bronchopneumonia 5 days
 Duration 7

8. AGE: Years 79 Months 8 Days 1 If less than one day hr. _____ min. _____

Due to Fracture - neck of Rt. Femur, 5-13-47.

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

Due to Senility

10. Usual occupation Retired

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

MOTHER FATHER
 11. Industry or business _____
 12. Name Frederich Griffith
 13. Birthplace Unknown
(City, town, or county) (State or foreign country)
 14. Maiden name Mary Anna Gamewell
 15. Birthplace Unknown
(City, town, or county) (State or foreign country)

PHYSICIAN
 Major findings: _____
 Of operations _____
 Of autopsy _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Minnie Cooper
 (b) Address 6649 Marquette
 17. (a) Burial (b) Date thereof June 7 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) Accident
 (b) Date of occurrence 5/13/1947
 (c) Where did injury occur? At Home
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
See above

(c) Place: burial or cremation Bellefontaine Cemetery
C. Holmeister Colonial Mortuary
 18. (a) Signature of funeral director _____
 (b) Address 6464 Chippewa St.

While at work? _____ (Specify type of place)
 (e) Means of death fall
 23. Signature J. F. Bredeek (M. D. number) _____
 Address 6006 Virginia Date signed 6-4-47

19. (a) JUN 5 1947 (b) J. F. Bredeek
(Date received local registrar) (Registrar's signature)

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

Dr. B. Pruett
6006 Virginia Ave.

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 Harry J. Schumacher
Licensed Embalmer No. 2679
P. O. Address 7819 T. Broadway

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.