3. No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 40462

FILED DEC 8 1947

Registration District No. 1947

Primary Registration District No. 6076

Registrar's No. 2460

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town Overland (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution 9710 Baltimore Av (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 yr (Specify whether
In this community 1 yr years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St Louis 96
(c) City or town Overland (If outside city or town limits, write "RURAL") 13
(d) Street No. 9710 Baltimore Av (If rural, give location)
(e) Citizen of foreign country? (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Louis Griffaw
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 Widowed
6. (b) Name of ~~husband or~~ wife Amanda
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased Nov (Month) 15 (Day) 1849 (Year)

8. AGE: Years 98 Months 0 Days 14 If less than one day hr. min.

9. Birthplace Perry Co (City, town, or county) Mo (State or foreign country) 0
10. Usual occupation Retired
11. Industry or business —
FATHER
12. Name Mike Griffaw
13. Birthplace Perry Co (City, town, or county) Mo (State or foreign country) 0
MOTHER
14. Maiden name Unkown
15. Birthplace Unkown (City, town, or county) (State or foreign country) 9
16. (a) Informant Talmadge Bailey
(b) Address 9710 Baltimore Av
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-1-47 (Month) (Day) (Year)
(c) Place: burial or cremation Lake Charles Cem
18. (a) Signature of funeral director Chas A Bull Mortuary
(b) Address 4355 Washington Av
19. (a) 12-1-47 (Date received local registrar) (b) Cecil A Sharp MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 29 year 1947 hour 11 minute 00 A M.
21. I hereby certify that I attended the deceased from Oct 44 19 to Nov. 28 1947 that I last saw him alive on Nov. 21 1929 and that death occurred on the date and hour stated above.

Immediate cause of death Nephritis attributing Comp. of Sinkety
Due to
Due to
Other conditions (Include pregnancy within 3 months of death) Dr. E. C. Smith
Major findings:
Of operations
Of autopsy

Duration

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

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 0
23. Signature Dr. E. C. Smith (M. D. or other)
Address 4659 Delmar Date signed 11-29-47

Jefferson City Printing Co.

(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 Van M. Sizemore

Licensed Embalmer No. 4343

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.

S. No. 2B
25M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Die

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 2465

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town overland
(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 years, months or days)

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

3. (a) PRINT FULL NAME Louis 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 Wid

6. (b) Name of husband or wife

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

7. Birth date of deceased Nov. (Month) 15 (Day) 1849 (Year)

8. AGE: Years 98 Months 2 Days 14 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 29
year 1947 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.
Immediate cause of death Nephritis Chronic - Interstitial

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

13 17

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 (M. D. or other)

Address Date signed 12-12-47

404662