

FILED DEC 16 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

Registration District No. 240 Primary Registration District No. 4357 Registrar's No. 37

1. PLACE OF DEATH a. COUNTY <u>New Madrid</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. <u>Missouri</u> b. COUNTY <u>New Madrid</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marston,</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Marston</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u>				Length of stay in lb		d. STREET ADDRESS (If outside, give location)			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)			First <u>Zelly</u>		Middle <u>Morten</u>		Last <u>Griffy</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>13,</u> Year <u>1957</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 19, 1863</u>		9. AGE (In years last birthday) <u>94</u>		IF UNDER 1 YEAR Month <u>5</u> Day <u>24</u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Ind.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>John Griffy</u>						14. MOTHER'S MAIDEN NAME <u>Sarah Boone</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>James Griffy, Marston, Missouri</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										DUE TO (b) <u>Arterio Sclerosis</u>		5 years	
DUE TO (c) <u>4201</u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Senile deterioration - normal</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Hour <u></u> Month <u></u> Day <u></u> Year <u></u> a. m. <u></u> p. m. <u></u>													
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)			20f. CITY, TOWN, OR LOCATION			COUNTY		STATE		
21. I attended the deceased from <u>12-1-52</u> , to <u>11-13-57</u> and last saw her/him alive on <u>11-13-57</u> Death occurred at <u>11:00</u> <u>A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>James O. Anderson D.O</u> (Degree or title)						22b. ADDRESS <u>Bloomfield-Mo</u>			22c. DATE SIGNED <u>11-20-57</u>				
22g. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>15 Nov. 57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mounds Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>Near New Madrid, Missouri</u>						
24. FUNERAL DIRECTOR ADDRESS <u>Richards Undertaking Co. Missouri</u>				25. DATE RECD. BY LOCAL REG. <u>Nov. 27 1957</u>		26. REGISTRAR'S SIGNATURE <u>H.L. Ponder Deputy</u>							

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Health,
Welfare
Public
Service300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

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(Licensed Embalmer's Statement on Reverse Side)

DATE RECEIVED NOV 30 1957
NEW MADRID CO. HEALTH CENTER

P. J. S.

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, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Tommy L. Roberts

Licensed Embalmer No. 488

P. O. Address New Madrid

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.