

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-023007
STATE FILE NUMBER

FILED JUL 11 1958 Registration District No. 314 Primary Registration District No. 4459 Registrar's No. 25

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| 1. PLACE OF DEATH a. COUNTY ST CLAIR | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY ST CLAIR | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN OSCEOLA | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN OSCEOLA |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION O.M. Hospital | | Length of stay in 1b 1 day | d. STREET (If outside, give location) ADDRESS 3-MI N-OSCEOLA |
| | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|---|--|--|---|--|--|
| 3. NAME OF DECEASED (Type or print) First Middle Last Edith Louise GRIFFS | | | 4. DATE OF DEATH Month Day Year JUNE 16 1958 | | |
|---|--|--|---|--|--|

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|-------------------------|----------------------------------|---|--|--|--------------------------------|--------------------------------|
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH APR 3, 1874 | 9. AGE (In years last birthday) 84 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
|-------------------------|----------------------------------|---|--|--|--------------------------------|--------------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE KEEPING | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) GRINNELL IOWA | 12. CITIZEN OF WHAT COUNTRY? USA |
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| 13a. FATHER'S NAME WILLIAM SADIN | 13b. MOTHER'S MAIDEN NAME MARTHA LOWE | 14. NAME OF HUSBAND OR WIFE - |
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| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO | 16. SOCIAL SECURITY NO. NONE | 17. INFORMANT MARY SEYMORE OSCEOLA MO | Address |
|---|--|---|---------|

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction | | INTERVAL BETWEEN ONSET AND DEATH 3 days | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Coronary Atherosclerosis | | 2 weeks |
| | DUE TO (c) _____ | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |

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| 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.) |
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|---|---|--|--|---------------------------|--------------------|
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. | 20d. INJURY OCCURRED WHILE AT <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 OSCEOLA | COUNTY ST CLAIR | STATE MO |
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| 21. I attended the deceased from Death occurred at 7:30 AM on the date stated above; and to the best of my knowledge, from the causes stated. | 22a. SIGNATURE J. H. [Signature] (Degree or title) | 22b. ADDRESS Lawrence City Mo. | 22c. DATE SIGNED 6-18-58 |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE 6-19-58 | 23c. NAME OF CEMETERY OR CREMATORY OSCEOLA | 23d. LOCATION (City, town, or county) (State) OSCEOLA MO |
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|--|------------------------------|---|---|
| 24. FUNERAL DIRECTOR Goodrich & Home | ADDRESS OSCEOLA MO | 25. DATE RECD. BY LOCAL REG. 7-5-58 | 26. REGISTRAR'S SIGNATURE [Signature] |
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Any omissions in Part I must be causally related.

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 *J. B. [Signature]*
Licensed Embalmer No. *3058*

P. O. Address *Osceola, Wis*

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.