

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038647
STATE FILE NUMBER

FILED OCT 28 1958 Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 149

1. PLACE OF DEATH a. COUNTY <u>Varner</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Polk</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington Township</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Bolivar</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital No. 3</u>		Length of stay in lb <u>6 1/2</u>	084 STREET ADDRESS <u>RT. 4</u> (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>ERMA</u> Middle <u>MAY</u> Last <u>GRIFFIN</u>			4. DATE OF DEATH Month <u>10</u> Day <u>13</u> Year <u>1958</u>			
--	--	--	--	--	--	--

5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-11-1913</u>	9. AGE (In years last birthday) <u>45</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
--------------------	-------------------------------	---	---------------------------------------	--	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Aldrich, Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
--	-----------------------------------	--	---

13a. FATHER'S NAME <u>Charles Griffin</u>	13b. MOTHER'S MAIDEN NAME <u>Golden Kirby</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
--	--	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Hospital records</u>	Address
--	--	--	---------

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 occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Atherosclerosis</u> 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"/>

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 _____ 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	COUNTY	STATE
---	--	------------------------------	--------	-------

21. I attended the deceased from 3/1 - 1956 to 10/13/1958 and last saw her/him alive on 10/13/1958
Death occurred at 6:15 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>W. C. Bradley M.D.</u> (Degree or title)	22b. ADDRESS <u>State Hospital #3 Nevada Mo</u>	22c. DATE SIGNED <u>10/13/1958</u>
---	--	---------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>15 Oct 58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mitchell Camp Grounds</u>	23d. LOCATION (City, town, or county) (State) <u>Polk Co. Mo.</u>
--	-------------------------------	--	--

24. FUNERAL DIRECTOR <u>Pitts Funeral Home</u>	ADDRESS <u>Bolivar, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>10-22-1958</u>	26. REGISTRAR'S SIGNATURE <u>Anna E. Jerry</u>
---	--------------------------------	---	---

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

300
1-57
2

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 *Lloyd C McLeod*

Licensed Embalmer No. *4853*

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