

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-003713  
STATE FILE NUMBER

FILED JAN 26 1959

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 200

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| 1. PLACE OF DEATH<br>a. COUNTY <u>St. Louis</u>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>                        |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Clayton</u><br>Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  | c. CITY OR TOWN <u>Kirkwood</u> <u>4770</u><br>Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                               |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>St. Louis Co. Hosp.</u><br>Length of stay in lb <u>2WKS.</u>                           |  | d. STREET ADDRESS (If outside, give location)<br><u>221 Alsbrook St.</u><br>Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |

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| 3. NAME OF DECEASED<br>(Type or print) <u>Robert J. Griggs</u><br>First Middle Last |  |  | 4. DATE OF DEATH<br><u>1 16 1959</u><br>Month Day Year |  |  |
|---|--|--|--|--|--|

|                    |                               |   |                                       |   |   |  |
|--------------------|-------------------------------|---|---------------------------------------|---|---|--|
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 25, 1912</u> | 9. AGE (In years last birthday) <u>46</u> | IF UNDER 1 YEAR<br>Months <u>6</u> Days <u>20</u> | IF UNDER 24 HRS.<br>Hours <u>0</u> Min. <u>0</u> |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Labor</u> | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>unk.</u> | 11. BIRTHPLACE (City and state or country)<br><u>Hickman Ky.</u> | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u> |
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| 13a. FATHER'S NAME<br><u>Robert Griggs Cr.</u> | 13b. MOTHER'S MAIDEN NAME<br><u>Lula Bennett</u> | 14. NAME OF HUSBAND OR WIFE<br><u>Elnora Griggs</u> |
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| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No.</u> | 16. SOCIAL SECURITY NO.<br><u>490-14 6337</u> | 17. INFORMANT<br><u>Elnora Griggs</u><br>Address <u>221 Alsbrook St.</u> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>UREMIA</u>                                       |   | INTERVAL BETWEEN ONSET AND DEATH  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.   | DUE TO (b) <u>CHRONIC PYELONEPHRITIS?</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)<br><u>HYPERTENSIVE CARDIOVASCULAR DISEASE 6000</u> |   | 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____<br>a.m. _____<br>p.m. _____ | 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 |
|---|--|--|------------------------------|--------|-------|

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| 21. I attended the deceased from <u>1-2-1959</u> to <u>1-16-1959</u> and last saw <sup>hear</sup> him alive on <u>1-16-1959</u><br>Death occurred at <u>1337</u> m on the date stated above; and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE<br><u>R. B. Kelly</u><br>(Degree or title) <u>M.D.</u> | 22b. ADDRESS<br><u>601 S. Brentwood Blvd.</u> | 22c. DATE SIGNED<br><u>1-17-59</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u> | 23b. DATE<br><u>Jan. 22, 1959</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Father Dickson Cem.</u> | 23d. LOCATION (City, town, or county) (State)<br><u>Crestwood Mo.</u> |
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| 24. FUNERAL DIRECTOR<br><u>John W. Hemphill</u><br>ADDRESS <u>408 S. Fillmore</u><br><u>Kirkwood 22, Mo.</u> | 25. DATE RECD. BY LOCAL REG.<br><u>1-21-59</u> | 26. REGISTRAR'S SIGNATURE<br><u>John C. Murphy M.D.</u> |
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(Licensed Embalmer's Statement on Reverse Side)

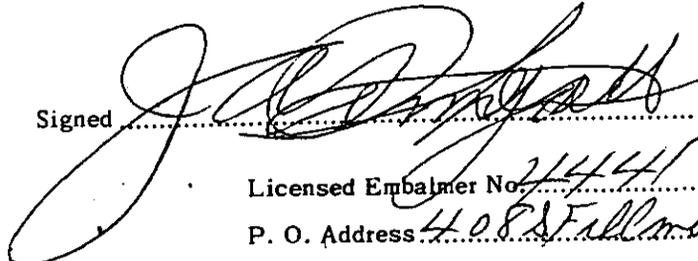
All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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  .....

Licensed Embalmer No. 21441 .....

P. O. Address 4088 Fullmer .....

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.