

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-004372

STATE FILE NUMBER

Health,  
Welfare  
Public  
Service

300  
-57

FILED MAR 11 1959 Registration District No. 4 Primary Registration District No. Registrar's No. 25

1. PLACE OF DEATH a. COUNTY <b>ATCHISON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>HOLT</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>FAIREAX</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>MOUND CITY</b> c 440
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Community Hosp.</b>		Length of stay in 1b <b>7 DAYS</b>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>DALE</b> Middle <b>EDDY</b> Last <b>GRIFFITH</b>			4. DATE OF DEATH Month <b>FEB.</b> Day <b>27</b> Year <b>1959</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAR 6 1907</b>	9. AGE (In years last birthday) <b>51</b> 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) <b>FARMER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>	11. BIRTHPLACE (City and state or country) <b>MOUND CITY, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>LESTER Griffith</b>	13b. MOTHER'S MAIDEN NAME <b>MARY E. NAUMAN</b>	14. NAME OF HUSBAND OR WIFE <b>MARGUERITE Griffith</b>	

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes w w II</b>	16. SOCIAL SECURITY NO. <b>491-42-3991</b>	17. INFORMANT <b>MARGUERITE Griffith, MOUND CITY, Mo.</b>	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) <b>myocardial infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Coronary artery insufficiency</b>		<b>1</b>
	DUE TO (c) <b>Coronary thrombosis</b>		<b>"</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>diabetes mellitus</b>		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 _____ 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	COUNTY	STATE
21. I attended the deceased from <b>July 4, 1952</b> to <b>Feb 27, 1959</b> and last saw <sup>her</sup> <sub>him</sub> alive on <b>Feb 27, 1959</b> Death occurred at <b>1 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <b>J. F.weeney</b>	(Degree or title) <b>m.d.</b>	22b. ADDRESS <b>Oregon, Mo.</b>	22c. DATE SIGNED <b>2/12/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>3-2-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MOUNT HOPE CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>MOUND CITY, MO.</b>
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24. FUNERAL DIRECTOR <b>Clarence Crawford</b>	ADDRESS <b>Mound City, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>Mar 8, 1959</b>	26. REGISTRAR'S SIGNATURE <b>Tharvin H. Schaefer</b>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

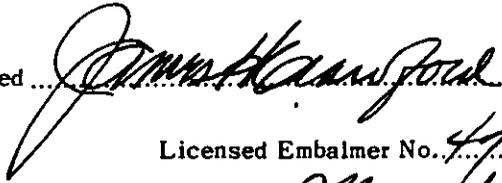
MEDICAL CERTIFICATION

All diseases 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 ..... 

Licensed Embalmer No. 4996.....

P. O. Address Mound City, 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.