

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-018692

STATE FILE NUMBER

FILED MAY 19 1959

Registration District No.

278

Primary Registration District No.

3054

Registrar's No.

66

1. PLACE OF DEATH a. COUNTY <b>PIKE</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>PIKE</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>LOUISIANA</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>CLARKSVILLE</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <b>PIKE CO. HOSPITAL</b>		Length of stay in lb INSTITUTION <b>5 DAYS</b>	d. STREET ADDRESS <b>RFD # 2.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>PATSY</b> Middle <b>MELVONA</b> Last <b>GRIFFITH</b>			4. DATE OF DEATH Month <b>MAY</b> Day <b>12</b> , Year <b>1959</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 16, 1884</b>	9. AGE (In years last birthday) <b>74</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>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	11. BIRTHPLACE (City and state or country) <b>PIKE COUNTY, MO.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>J. A. TURNER</b>		13b. MOTHER'S MAIDEN NAME <b>SARAH ELIZABETH KELLY</b>		14. NAME OF HUSBAND OR WIFE <b>H.C. GRIFFITH</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>497-42-1580</b>	17. INFORMANT <b>ORVILLE GRIFFITH, RT. #2, CLARKSVILLE</b>		
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>Acute Left sided Heart Failure</b>					INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic Cardiovascular Dis.</b>					<b>5 yrs</b>
DUE TO (c) <b>and Arterio-sclerotic structure left</b>					<b>12 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>hep incurred in a fall beside</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.) <b>bed while in Pike County Hospital</b>		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. <b>1 442XF</b>					
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>5-28-58</b> to <b>5-12-59</b> and last saw her <sup>her</sup> alive on <b>5-11-59</b> Death occurred at <b>12:02 A.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Chas H. Lavelle</b> (Degree or title) <b>M.D.</b>			22b. ADDRESS <b>LOUISIANA, MISSOURI</b>		22c. DATE SIGNED <b>5-12-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>MAY 14, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GREENWOOD CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>CLARKSVILLE, MISSOURI</b>
24. FUNERAL DIRECTOR <b>George O. Nagner</b>		ADDRESS <b>LOUISIANA, MO.</b>		25. DATE RECD. BY LOCAL REG. <b>May 14, 1959</b>	26. REGISTRAR'S SIGNATURE <b>Verneer Collier</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MAR 22 1961

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

*George O. Hagner*

Licensed Embalmer No. 3773

P. O. Address LOUISIANA, 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.