

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-015065

FILED VS MAY 12 1960

140

Primary Registration District No. 3024

Registrar's No. 50

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Howard</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Howard</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Fayette</b>		Length of stay in 1b <b>9 1/2 yrs</b>	c. CITY OR TOWN <b>Fayette</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Wells Rest Haven</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>400 N. Mulberry</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>CALVIN</b> Middle <b>EDWARD</b> Last <b>GRIFFIN</b>			4. DATE OF DEATH Month <b>May</b> Day <b>8</b> , Year <b>1960</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12/23/1876</b>	9. AGE (last birthday) <b>83</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>
IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>	11. BIRTHPLACE (City and state or country) <b>Howard Co. Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>George Griffin</b>		13b. MOTHER'S MAIDEN NAME <b>Ada Ellen Thompson</b>		14. NAME OF HUSBAND OR WIFE <b>-----</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>None</b>	17. INFORMANT Address <b>Raymond M. West Kansas City, Mo</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>Cerebrovascular Thrombosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis Generalized</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>unknown</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 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
21. I attended the deceased from <b>Sept 1953</b> to <b>May 8 1960</b> and last saw <sup>her</sup> him alive on <b>May 3 1960</b> Death occurred at <b>8:30 P.m</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>James J. Dean MD</i> (Degree or title)			22b. ADDRESS <i>Fayette, Mo</i>		22c. DATE SIGNED <b>10 May 1960</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>5/10/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Atkins Cemetery</b>	23d. LOCATION (City, town, or county) <b>Howard Co. Missouri</b> (State)		
24. FUNERAL DIRECTOR <i>Ralph A. Case</i> ADDRESS <b>Fayette, Mo</b>		25. DATE RECD. BY LOCAL REG. <b>5-10-60</b>	26. REGISTRAR'S SIGNATURE <i>Katherine Welch</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

