

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS AUG 22 1960

-60-031197

Registration District No. 383 Primary Registration District No. 5655 Registrar's No. 69

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Lawrence		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Mt. Vernon		Length of stay in 1b 711 days	c. CITY OR TOWN South Kinloch Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. State Sanatorium		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 628 Lyons Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Walter Middle Rassel Last Griffin			4. DATE OF DEATH Month August Day 15 Year 1960		
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5. SEX Male	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH May 14, 1920	9. AGE (last birthday) 40	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Universal Match Corp.	11. BIRTHPLACE (City and state or country) South Kinloch, Mo.	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME John Griffin	13b. MOTHER'S MAIDEN NAME Grace Clay	14. NAME OF HUSBAND OR WIFE Frances Griffin
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 1942-1943	16. SOCIAL SECURITY NO. 488-28-5952	17. INFORMANT San. recrods, Mo. State San., Mt. Vernon, Mo.	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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Massive Pulmonary Hemorrhage		Minutes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Tuberculosis, Pulmonary, Far Advanced, Active	10 years
	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"/> N. <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour 1:10 a.m. Month, Day, Year 9-4-58	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION St. Louis, Mo.	COUNTY St. Louis	STATE
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21. I attended the deceased from **9-4-58** to **8-15-60** and last saw him alive on **8-14-60**
 - Death occurred at **1:10 a.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE David R. Wilson (Degree or title) MD	22b. ADDRESS Mt. Vernon, Missouri	22c. DATE SIGNED 8-15-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 8-15-60	23c. NAME OF CEMETERY OR CREMATORY Washington Park Cem	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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24. FUNERAL DIRECTOR Royd Bro F Home Kinloch Mo	ADDRESS Aug 15-1960	25. DATE RECD. BY LOCAL REG. Aug 15-1960	26. REGISTRAR'S SIGNATURE W H Lassett
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DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

AUG 23 1960

AUG 29 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed W B Lassett

Licensed Embalmer No. 220

P. O. Address mt hew

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his OWN HANDWRITING. (Failure to
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.