

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

W-21  
-60-035493  
STATE FILE NUMBER

FILED VS OCT 5 1960

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 387

1. PLACE OF DEATH a. COUNTY <b>Marion</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Marion</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Hannibal</b>			Length of stay in 1b		c. CITY OR TOWN <b>Hannibal</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Levering Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>702 Lemon Street</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Ethel</b> Middle <b>Louise</b> Last <b>Griffie</b>				4. DATE OF DEATH Month <b>September</b> Day <b>20</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</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>Jan. 30, 1914</b>	9. AGE (last birthday) <b>46</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HR
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		11. BIRTHPLACE (City and state or country) <b>Sedalia, Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Samuel Taylor</b>			13b. MOTHER'S MAIDEN NAME <b>Sally Grimes</b>		14. NAME OF HUSBAND OR WIFE <b>Maxwell Griffie</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>488-24-8565</b>		17. INFORMANT <b>Mr. Maxwell Griffie</b> Address <b>1265 Collier Hannibal, Missouri</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>Cardiac standstill</b> DUE TO (b) <b>Hypertensive Cardiovascular disease</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
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	
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 _____ a.m. _____ p.m. Month, Day, Year _____							
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>Aug 1960</b> to <b>present</b> and last saw her/him alive on <b>20 Sept 1960</b> Death occurred at <b>8:15 A.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Walter Hamlin MD</b>				22b. ADDRESS <b>Hannibal Mo.</b>		22c. DATE SIGNED <b>23 Sept 1960</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Sept. 22, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Robinson Cemetery</b>		23d. LOCATION (City, town, or county) <b>Hannibal, Missouri</b>		(State)	
24. FUNERAL DIRECTOR <b>Geo E. Roberts</b> ADDRESS <b>1218 Broadway Hannibal, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>9/27/60</b>		26. REGISTRAR'S SIGNATURE <b>Dr. E. M. Lucke by William M. Heron</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

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

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed George E. Roberts  
George E. Roberts

Licensed Embalmer No. 2113

P. O. Address Hannibal, Missouri

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