

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-044594

FILED VS NOV 28 1960

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 3313

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| 1. PLACE OF DEATH a. COUNTY <i>St Louis</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MO</i> b. COUNTY <i>St Louis</i> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Richmond Heights</i> | | Length of stay in 1b <i>5 MIN.</i> | c. CITY OR TOWN <i>Richmond Heights</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>St Marys Hosp. 8d</i> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <i>7622 GENERAL SHERMAN LANE</i> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |

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|---|-------------------------------|--|---|--|---|---|
| 3. NAME OF DECEASED (Type or print) First Middle Last <i>Bealy (MARR) Griffith</i> | | | 4. DATE OF DEATH Month Day Year <i>11 12 60</i> | | | |
| 5. SEX <i>Fe</i> | 6. COLOR OR RACE <i>White</i> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <i>11-12-60</i> | 9. AGE (last birthday) | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NONE</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>---</i> | | 11. BIRTHPLACE (City and state or country) <i>RICHMOND HEIGHTS MO</i> | | 12. CITIZEN OF WHAT COUNTRY <i>USA</i> |
| 13a. FATHER'S NAME <i>John D. Griffith</i> | | 13b. MOTHER'S MAIDEN NAME <i>Joan Leonard</i> | | 14. NAME OF HUSBAND OR WIFE <i>---</i> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i> | | 16. SOCIAL SECURITY NO. <i>NONE</i> | | 17. INFORMANT <i>JOHN D. GRIFFITH JR</i> Address <i>7622 GENERAL SHERMAN LANE</i> | | |

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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) <i>intra-cranial hemorrhage</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>5 min</i> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <i>Prematurity + labor</i> | |
| | DUE TO (c) | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Head struck by swinging door & premature rupt of Bow</i> | | 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 | |
|--|--|--|--|

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| 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.) <i>Head struck by swinging door & premature rupt of Bow</i> | |
| 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 *11-12-60* to *11-12-60* and last saw her alive on *11-12-60*
Death occurred at *130A* m on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) <i>M.A. Correnti M.D.</i> | 22b. ADDRESS <i>150 N. Euclid Ave (E)</i> | 22c. DATE SIGNED <i>11-12-60</i> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> | 23b. DATE <i>NOV 14 1960</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>RESURRECTION CEM</i> |
| 23d. LOCATION (City, town, or county) <i>ST LOUIS MO</i> | | 23e. STATE <i>MO</i> |

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| 24. FUNERAL DIRECTOR <i>Thomas Kuntz 2906 Gravois</i> | 25. DATE RECD. BY LOCAL REG. <i>11-14-60</i> | 26. REGISTRAR'S SIGNATURE <i>John P. Murphy Md</i> |
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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 Elena Province

Licensed Embalmer No. 3403

P. O. Address 2906 J...

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.