

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-003526

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 239 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DOCUMENT

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u> | | c. CITY OR TOWN <u>ST. LOUIS</u> | |
| Length of stay in 1b | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>LUTHERAN HOSPITAL</u> | | d. STREET ADDRESS (If outside, give location) <u>3728 TEXAS</u> | |
| Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>JEWELL GRIFFEY</u> | | | 4. DATE OF DEATH Month Day Year <u>JAN 7 1963</u> |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>SEPT. 11, 1916</u> |
| 9. AGE (last birthday) <u>46</u> | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEAMSTRESS</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <u>Mo</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | 13a. FATHER'S NAME <u>OSCAR TESSON</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>ELIZABETH ADAMS</u> | | 14. NAME OF HUSBAND OR WIFE <u>WALTER GRIFFEY</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) | | 16. SOCIAL SECURITY NO. <u>[REDACTED]</u> | |
| 17. INFORMANT <u>WALTER GRIFFEY 3728 TEXAS</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Carcinomatosis Generalized</u> DUE TO (b). <u>Malignant retroperitoneal lymphoma</u> DUE TO (c). <u>3 yrs.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u> <u>3 yrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>2.0.2.1</u> | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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. | 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 <u>1/18/60</u> to <u>1/7/63</u> and last saw her <u>alive</u> on <u>1/7/63</u> Death occurred at <u>8:20 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <u>Robert H. Carson, M.D.</u> (Degree or title) | | 22b. ADDRESS <u>4401 Hampton Ave.</u> | |
| 22c. DATE SIGNED <u>1/8/63</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u> | 23b. DATE <u>JAN 10, 1963</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>MT. HOPE Cem.</u> | 23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Co Mo</u> |
| 24. FUNERAL DIRECTOR <u>Thomas Kulis 2906 Gravois</u> ADDRESS | | 25. DATE RECD. BY LOCAL REG. <u>JAN 9 1963</u> | 26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u> |

USE BLACK INK OR TYPEWRITER RIBBON

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

As Case 4401 *Amputation*

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 *Carly Thompson Jr.*

Licensed Embalmer No. *4861*

P. O. Address *St. Louis 19, 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.