

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County Wentz
Township West Springfield
or
Village _____
or
City Salmon (NO _____)

Registration District No. 266 File No. 651-10
Primary Registration District No. 5370 Registered No. 100
St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Winifred B. Griffin

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)
DATE OF BIRTH Jan 29, 1909
(Month) (Day) (Year)
AGE 5 yrs. 11 mos. 9 ds.
If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) _____

DATE OF DEATH: Jan 8, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from August, 1914, to Jan 8, 1915, that I last saw her alive on Jan 6, 1915, and that death occurred, on the date stated above, at 4 a. m.
The CAUSE OF DEATH* was as follows:
2003

BIRTHPLACE (City or town, State or foreign country) Salmon Mo.

PARENTS
NAME OF FATHER Ross E. Griffin
BIRTHPLACE OF FATHER (City or town, State or foreign country) Salmon Mo.
MAIDEN NAME OF MOTHER Rhoda M. Vanhook
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Salmon Mo.

(Duration) ___ yrs. 4 mos. ___ ds.
Contributory (SECONDARY) _____
(Duration) ___ yrs. ___ mos. ___ ds.
(Signed) A. J. McWhorter M. D.
Jan 8, 1915 (Address) Salmon Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury; and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ross E. Griffin
(ADDRESS) Salmon Mo.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death 6 yrs. 11 mos. 9 ds. In the State 1 yrs. 11 mos. 9 ds.
Where was disease contracted If not at place of death? at place of death
Former or usual residence _____

Filed Jan 8, 1915, J. B. Stelch REGISTRAR

PLACE OF BURIAL OR REMOVAL Cedar Grove Cem DATE OF BURIAL 1/9, 1915
UNDERTAKER J. B. Stelch ADDRESS Salmon

N. B.—Every item of information should be carefully supplied. AGE cannot be stated in years. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc. of (name origin; "Cancer" is less definite; avoid

use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH St. Louis
County West St. Louis
Township West St. Louis
or
Village
or
City

Registration District No. 266 File No. _____
Primary Registration District No. 5370 Registered No. 100
(NO. _____) St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Levathy B. Griffin

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE S MARRIED S WIDOWED S OR DIVORCED S
(Write the word)

DATE OF BIRTH _____, 191____
(Month) (Day) (Year)

AGE _____ If LESS than 1 day, _____ hrs. or _____ min. _____ mos. _____ ds.

OCCUPATION (a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed, (or employer) _____

BIRTHPLACE (City or town, State or foreign country) _____

PARENTS NAME OF FATHER _____ BIRTHPLACE OF FATHER (City or town, State or foreign country) _____ MAIDEN NAME OF MOTHER _____ BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) _____ (ADDRESS) _____

Filed Jan 8 1915 J. B. Welch REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 8, 1915
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h. _____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Dr. doesn't know what caused death.
(Duration) 184 yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) A. J. McMurtry M. D. 178 1951 (Address) Saline Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) _____
At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted if not at place of death? _____
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Calvary Ave DATE OF BURIAL 1/9 1915
UNDERTAKER N. D. Hobson ADDRESS Saline Mo.

Satisfactory Information Supplied

SUPPLEMENTARY

Satisfactory Information Supplied

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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D-159