

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

Do not use this space.

3166

1. PLACE OF DEATH

County St. Charles
Township Cresse
City..... (No.....)

Registration District No. 760
Primary Registration District No. 15999

File No.
Registered No. 68
St. Ward)

2. FULL NAME

John Edward Griffin

(a) Residence Fallon Mo. R. St. 3 Ward.....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF X

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 25 - 1875

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
54 2 21

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St. Charles Co. Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER Adam Griffin

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Germany
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Wasschhaus

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Germany
(STATE OR COUNTRY)

14. Informant Par Adam Griffin
St. Louis Mo.

15. Filed 1/16, 1929 Dr. J. M. Jenkins REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 15 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 15 1929, to Jan 15 1929, and that I last saw him alive on Jan 15 1929, and that death occurred, on the date stated above, at 11 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Inf. H. Apoplexy
77 (duration) yrs. mos. da.
CONTRIBUTORY (SECONDARY) 77 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) L. C. Owens M. D.
, 19 (Address) Fallon, Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St. Paul Mo. DATE OF BURIAL 1/19 1929

20. UNDERTAKER Ed. Kertley ADDRESS Fallon Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

53-1-20

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