

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

Do not use this space.

MAY 28 1930

13806

1. PLACE OF DEATH

County St. Louis Registration District No. 784 File No. _____
 Township _____ Primary Registration District No. 60301 Registered No. _____
 City _____ (No. St. Louis Training School St. _____ Ward _____)

2. FULL NAME

Robert Griffin

(a) Residence No. 1727 Carroll St. _____ Ward _____
 (Usual place of abode)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Nov 22, 1917

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>13</u>	<u>5</u>	<u>4</u>	

8. OCCUPATION OF DECEASED

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

School boy

9. BIRTHPLACE (CITY OR TOWN)

St. Louis, Mo.

10. NAME OF FATHER

Harvey Griffin

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Illinois

12. MAIDEN NAME OF MOTHER

Marabel Training

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Quincy, Illinois

14.

INFORMANT

Records of St. Louis Training School

15.

FILED

5/27 1930 O. W. Schutte M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Apr 26, 1930

17.

I HEREBY CERTIFY, That I attended deceased from April 25, 1930 to April 26, 1930, that I last saw him alive on April 25, 1930, and that death occurred, on the date stated above, at 12:13 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Concussion - cerebral
epileptic seizure

CONTRIBUTORY (SECONDARY)

epilepsy and imbecility

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

18 DID AN OPERATION PRECEDE DEATH? DATE OF

18 WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Dr. R. M. Ellersiek, M. D.

4-26, 1930 (Address) St. Louis Training School

*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

DATE OF BURIAL

Calvary Cemetery

4-28 1930

20. UNDERTAKER

ADDRESS

M. O. Raughlin

1631 Monroe

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.

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County St. Louis Registration District No. 984 File No.
 Township St. Ferdinand Primary Registration District No. 6030 Registered No.
 City (No.) St. Ward)

2. FULL NAME Robert Griffin

(a) Residence. No. St. Ward.
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 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 S (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 22-1917

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
✓ 12 X 5 4

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN)
 (STATE OR COUNTRY)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT
 (Address)

15. FILED 3/9/30 O. N. Schutte M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 26 1930

17. I HEREBY CERTIFY, That I attended deceased from 19..... to 19..... that I last saw h..... after on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.
 , 19 (Address)

*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

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

19

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

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

SUPPLEMENTARY

S-13806