

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

Do not use this space.

16036

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **100B**

City *St. Louis* (No. *City Hosp.*)

File No.

Registered No. **4512**

St. Ward)

2. FULL NAME

(a) Residence, No. *204 N. 14th* *Walden* (Usual place of abode) *Walden* (If nonresident, give city or town and State)

Length of residence in city or town where death occurred *49* yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *widowed*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Oct. 3 - 1862*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
68 6 9

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Laborer*
(b) General nature of industry, business, or establishment in which employed (or employer) *237*
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) *Illinois*

PARENTS

10. NAME OF FATHER *John Griffin*

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) *Ill*

12. MAIDEN NAME OF MOTHER *Ann Wall*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) *Mo.*

14. Hospital informant (Address) *Hospital Informant, City of St. Louis*

15. FILED *14 1931* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *April 12 1931*

17. I HEREBY CERTIFY, That I attended deceased from *April 10 1931* to *April 12 1931* that I last saw him alive on *April 12 1931*, and that death occurred, on the date stated above, at *12:45 P. m.*

93C THE CAUSE OF DEATH* WAS AS FOLLOWS:

109A
Pneumonia
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *Ch. Myocarditis*
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? *No* DATE OF

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical*

(Signed) *George J. Simon*, M. D.

413 (Address) *City Hosp*

*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

Palatka *April 15 1931*

20. UNDERTAKER

ADDRESS

Edw. J. Howard & Son *4212 St Louis Ave*

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.

