

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

Do not use this space.
31835

1. PLACE OF DEATH
 29 County Wade Registration District No. 237
 5 Township _____ Primary Registration District No. 4144
 2 City Greenfield mo (No. _____) St. _____ Ward _____
 2. FULL NAME Charles Griffith
 (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.

File No. _____
 Registered No. 37

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. ~~SINGLE~~ MARRIED, WIDOWED OR DIVORCED (write the word) 2
 5A. ~~IF~~ MARRIED, WIDOWED, OR DIVORCED HUSBAND OF - (OR) WIFE OF Irene Crockett
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2-28-1889
 7. AGE ~~47~~ YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
43 7 29
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Salesman 112
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Lebanon, mo (STATE OR COUNTRY) 1

10. NAME OF FATHER Ben Griffith
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Rogers Ark. (STATE OR COUNTRY) _____
 12. MAIDEN NAME OF MOTHER Georgia Browning
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Linsburg, mo (STATE OR COUNTRY) 1

14. INFORMANT Kayel Smith
 (Address) 623 E. Pacific Springfield

15. FILED 10-26-32 O. O. Bell
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-27-1932
 17. I HEREBY CERTIFY, That I attended deceased from June 29th, 1932, to Oct 27th, 1932; that I last saw him... alive on Oct 24th, 1932, and that death occurred, on the date stated above, at 9:10 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tuberculosis,
Arthritis
23A
57A (duration) 3 yrs. mos. da.

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH Ft Worth, Texas

DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS clinical
 (Signed) P. A. Brown, M. D.
 , 19 _____ (Address) Lakewood mo 134

*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 Springfield DATE OF BURIAL 10-29-1932
Springfield

20. UNDERTAKER Lloyd W. Fox ADDRESS Springfield
629 W. Walnut

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.

NOV 23 1932

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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 Dade

Registration District No. 239

Township Greenfield

Primary Registration District No. 4144

City Greenfield (No.)

File No.

Registered No. 37

St. Ward)

2. FULL NAME

Charles Griffith

(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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

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

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation.

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

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. UNDERTAKER (ADDRESS)

20. FILED 12-1 1932 Scott

Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-27-1932

22. I HEREBY CERTIFY, That I attended deceased from to , 19

I last saw h..... alive on....., 19..... Death is said

to have occurred on the date stated above, at.....m.

The principal cause of death and related causes of importance were as follows:

Tuberculosis
Arthritis
lungs

Date of onset

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury , 19

Where did injury occur?

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) , M. D.

(Address)

SUPPLEMENTARY

23

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.

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

S-31825