

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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

30025
Do not use this space.

REC'D SEP 8 1939

1. PLACE OF DEATH

(a) County Ray Registration District No. 744

(b) Township Richmond Primary Registration District No. 3035 Registered No. 239

(c) City Richmond (d) Street No. Richmond Hospital St.

(If death occurred in Hospital or Institution, write its name instead of street and number)

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

2. PRINT FULL NAME No name given (died shortly after birth).

(a) Residence, No. Richmond Missouri St. (If nonresident, give city or town and State)

(Usual place of abode, if no street address, write county or city)

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) 8-21-39

7. AGE YEARS MONTHS DAYS If LESS than 1 day 10 hrs. or 10 min.

OCCUPATION

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

9. Industry or business in which work was done, as 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) Richmond (STATE OR COUNTRY) Mo

FATHER

13. NAME Arvilla Elroy Griffen

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

MOTHER

15. MAIDEN NAME Catherine Christine Griffen

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

17. INFORMANT Arvil Elroy Griffen (ADDRESS) Richmond Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE New Hope Cemetery DATE 8-21-39

19. FUNERAL DIRECTOR (NAME) Buried by family (ADDRESS)

20. FILED Aug 31 1939 Maluff Jackson Reg Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-21-39 19

22. I HEREBY CERTIFY, That I attended deceased from 8-21-39, 19, to 8-21-39, 19.

I last saw him alive on 8-21-39, 19. Death is said to have occurred on the date stated above, at 1:12 a.m.

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

Asphyxiation

Date of onset 16/6

Other contributory causes of importance: Mother had a placenta previa.

Name of operation none Date of

What test confirmed diagnosis? P. Ex. Was there an autopsy? no

(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? no

If so, specify (Signed) H. M. Griffith, M.D. (Address) Richmond Mo

RECEIVED
District Health Officer No. 8
District File Number
Date Filed 9/6/39

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.