

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

1939 OCT 16 1939

33400
Do not use this space.

1. PLACE OF DEATH
 (a) County ST FRANCOIS Registration District No. 774
 (b) Township _____ Primary Registration District No. 4465 Registered No. 893
 (c) City FLAT RIVER (d) Street No. _____
 (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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME ALONZO GRIFFIN
 (a) Residence, No. FLAT RIVER 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) MARRIED
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF MARY GRIFFIN
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) FEB. 23 1872
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
67 6 22
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Laborer
 9. Industry or business in which work was done, as saw mill, bank, etc. odd jobs
 10. Date deceased last worked at this occupation (month and year) 1939 11. Total time (years) spent in this occupation 39
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MO
 FATHER 13. NAME JAMES GRIFFIN
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo
 MOTHER 15. MAIDEN NAME OK
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) OK
 17. INFORMANT JODIE GRIFFIN
 (ADDRESS) LEADWOOD MO
 18. BURIAL, CREMATION, OR REMOVAL PLACE BONNE TERRE DATE SEPT 14 1939
 19. FUNERAL DIRECTOR J.S. BOYER & SON
 (ADDRESS) LEADWOOD MO
 20. FILED 9/20 1939 B. Barrar Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 12 1939
 22. I HEREBY CERTIFY That I attended deceased from Sept 9 1939 to Sept 12 1939
 I last saw him alive on Sept 12 1939. Death is said to have occurred on the date stated above, at 6:30 m.
 The principal cause of death and related causes of importance were as follows:
Bronchial pneumonia Hypertension Cardiomegaly Generalized arteriosclerosis
 Date of onset 9/10/39
 Other contributory causes of importance: None
 Name of operation none Date of _____
 What test confirmed diagnosis? none Was there an autopsy? no
 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) John W. Knight, M. D.
 (Address) Leadwood Mo

STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E.

No. or by, Registered Apprentice No.

working under my personal supervision.

Signed

Bert L. Boyer

Licensed Embalmer No. *3445*

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.)