

NY 13 1940 321.
Registration District No.

Primary Registration District No. 5444.

State File No. _____
Registrar's No. 8

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Springfield
(c) Name of hospital or institution: (Rural) R#3, City
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days

8. (a) PRINT FULL NAME Jennie Naomi Griffith
8. (b) If veteran, name war _____
8. (c) Social Security No. _____

4. Sex F 5. Color or race W
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased May 12, 1860
(Month) (Day) (Year)

8. AGE: Years 79 Months 10 Days 16
If less than one day _____ hr. _____ min.

9. Birthplace Rolla Mo
(City, town, or county) (State or foreign country)

10. Usual occupation House keeper

11. Industry or business _____

MOTHER FATHER
12. Name William Biggs
13. Birthplace Mo
(City, town, or county) (State or foreign country)
14. Maiden name Mary Painter
15. Birthplace Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Eula Hawkins
(b) Address Route 3, Springfield, Mo.

17. (a) Burial (b) Date thereof 3-31-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation McConnell Cem. Christian

18. (a) Signature of funeral director Dunn Funeral Home
(b) Address Springfield, Mo.

19. (a) 4-80-40 (b) McConnell, Hepler & Mitchell
(Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Greene
(c) City or town Springfield, Route 3, Mo.
(d) Street No. Route 3,
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 28,
year 1940 hour 11 minute 32 A.M.

21. I hereby certify that I attended the deceased from 3/15/40 to 3/28/40
that I last saw her alive on 3/28/40
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Colon
Duration 6 mos

Due to _____
Due to _____

Other conditions Senility
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place)
While at work? _____ (e) Means of injury _____

Signature J. E. Feller (M. D. or other)
Address Springfield, Mo. Date signed _____

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.

RECEIVED

Greene County Health Office,

County File Number 40-5-22

Date Filed 5-6-40

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

Hayd W. Fox

Licensed Embalmer No. 2910

P. O. Address 629 W Walnut

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.