

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

24237
2847

State File No. _____
Registrar's No. _____

Registration District No. 399 Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2332 Fairmount
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME JOHN JOSEPH GRIFFIN

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced. Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 11, 1940
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
5 hr. min.

9. Birthplace Kansas City Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business 1

12. Name Bruce Griffin

13. Birthplace Fort Smith, Ark.
(City, town, or county) (State or foreign country)

14. Maiden name Dorothy May Ruth

15. Birthplace St. Joseph, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Bruce Griffin

(b) Address 437 Nebraska, K.C., Mo.

17. (a) burial (b) Date thereof 7/17/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Hill

18. (a) Signature of funeral director Zwick & Fisher Co.

(b) Address H. C. Jno.

19. (a) July 16, 1940 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Wyandotte

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 437 Nebraska
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 16 day July
year 1940 hour 6 minute 10 A. M.

21. I hereby certify that I attended the deceased from July 11, 1940 to July 16, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral haemorrhage

Due to Breech Birth
Premature

Due to 1600

Other conditions 1600
(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?

While at work? _____ (Specify type of place)
(e) Means of injury 1

23. Signature C. M. Council M.D. (M. D. or other)

Address 208 W 17th St Date signed 7/16/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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. 4097

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.