

Registration District No. **689**

Primary Registration District No. **3033**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County **Peke**  
(b) City or town **Louisiana**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **Pike County Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **Hospital 2 days**  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days) **1**

3. (a) PRINT FULL NAME **George Griffin**  
8. (b) If veteran,  name war \_\_\_\_\_ 8. (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 **Sep 6 1906**  
(Month) (Day) (Year)

8. AGE: Years **34** Months **2** Days **16** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation **Farm laborer**

11. Industry or business **Farm**

12. Name **George R Griffin**

13. Birthplace **See**  
(City, town, or county) (State or foreign country)

14. Maiden name **Katie Greenfeller**

15. Birthplace **See**  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Hospital Record**  
(b) Address \_\_\_\_\_

17. (a) **Rural** (b) Date thereof **11/24/40**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Grandin (Cem) Mo**

18. (a) Signature of funeral director **Peterson**  
(b) Address **Louisiana Mo**

19. (a) **11/22/40** (b) **Peterson**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Mo** (b) County **Carter**  
(c) City or town **Grandin Mo**  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Nov** day **22**  
year **1940** hour **7** minute **45** M.  
21. I hereby certify that I attended the deceased from **Nov 20**  
**1940** to **Nov 22 1940**  
that I last saw him alive on **Nov 22**, 19**40**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Concussion**  
**Compound fracture left tibia**  
**& fibula** Duration **2 days**  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (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) **accident**  
(b) Date of occurrence **11/20/40**  
(c) Where did injury occur? **Pike Co. See**  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, or in industrial place, in public place?  
**On highway 54 between Atlas & Pike**  
While at work? **No** (Specify type of place) (e) Means of injury **Auto accident**

23. Signature **Infante Pitts II** (M. D. certifier)  
Address **Louisiana Mo** Date signed **4/23/40**

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

Rev. 5-17-39 I X1951

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.

FILED DEC 1 1940

RECEIVED

District Health Officer No. 10

District File Number 12-40-2246

Date Filed DEC 7 1940

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.....

George O. Hagner

Registered Apprentice No.....

working under my personal supervision.

Signed George O. Hagner

Licensed Embalmer No. 3773

P. O. Address Louisiana Mo

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 39502  
Registrar's No. \_\_\_\_\_

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 689

Primary Registration District No. 3033

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

1. PLACE OF DEATH:

(a) County Polk  
(b) City or town Louisiana  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME George Griffin

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced s

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
34 2 16 hr. min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 22  
year 1940 hour 8 minute 15 PM.

21. I hereby certify that I attended the deceased from Nov. 20, 1940  
to Nov. 22, 1940;  
that I last saw him alive on Nov. 22, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral concussion  
Compound fracture left tibia & fibula  
Due to Being hit by an automobile while walking on Highway 54 in Polk Co., Mo., on 11/24/40

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

PHYSICIAN  
Underline the cause to which death should be charged statistically.

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

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence 11-20-1940

(c) Where did injury occur? Polk Co., Mo. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Highway 54 (Specify type of place)  
While at work? No (e) Means of injury auto acc

23. Signature Eugene Pitts, M.D. (M. D. number) M.D.  
Address and V. George, Louisiana, Mo. Date signed 1/30/41

SUPPLEMENTAL

1940

S-39502