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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 42005

FEB JAN 13 1941

Registration District No. 1004 Primary Registration District No. 3008 Registrar's No. 322

1. PLACE OF DEATH

(a) County Callaway

(b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hospital #1, Fulton
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 weeks. (Specify whether years, months or days)

In this community 3

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Boone

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

(d) Street No. None
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Sarah T Griggs

3. (b) If veteran, name war

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Francis M. Griggs

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

7. Birth date of deceased Jan (Month) 4 (Day) 1867 (Year)

8. AGE: Years 73 Months 11 Days 0 If less than one day hr. min.

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

10. Usual occupation House wife

11. Industry or business Home

FATHER
12. Name William Clayton
13. Birthplace OK (City, town, or county) US (State or foreign country)

MOTHER
14. Maiden name Sarah Hulen
15. Birthplace OK (City, town, or county) U.S. (State or foreign country)

16. (a) Informant State Hospital #1, Fulton
(b) Address Fulton, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-4-40 (Month) (Day) (Year)

(c) Place: burial or cremation Overhall Mo

18. (a) Signature of funeral director [illegible]
(b) Address Overhall Mo

19. (a) 12-4-40 (Date received local registrar) (b) R. N. Crews (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 4 year 1940 hour 8 minute 00 A. M.

21. I hereby certify that I attended the deceased from Oct 17, 1940, to Dec 4, 1940 that I last saw her alive on Dec. 4, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebal Thrombosis	6 days
Due to	
Due to	
Other conditions Arteriosclerotic Heart Disease (Include pregnancy within 3 months of death)	indef

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)
(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

23. Signature [illegible] (M. D. or other)
Address Fulton Mo Date signed 2/4/40

(Licensed Embalmer's Statement on Reverse Side)

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 M J McDonald

Licensed Embalmer No. 2589

P. O. Address Centralia 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, fact should be so stated above.