

1-4-41  
17-39  
X2539

FILED SEP 10 1941 85  
Registration District No.

Primary Registration District No. 1001

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

1. PLACE OF DEATH:

(a) County BUCHANAN

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

(c) Name of hospital or institution: O. MO. METH. HOSPITAL  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 DAYS  
(Specify whether years, months or days)

In this community ABT-15-YRS.

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County BUCHANAN

(c) City or town ST. JOSEPH.  
(If outside city or town limits, write "RURAL")

(d) Street No. MYR-LAWN-ADD.  
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ANNA-LAURA-GRIFFIN

(b) If veteran, name war NO

(c) Social Security No. NO

4. Sex Female 5. Color White

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

(b) Name of husband or wife John W. Griffin

(c) Age of husband or wife if alive 48 years

7. Birth date of deceased April 27 1893  
(Month) (Day) (Year)

8. AGE: Years 48 Months 3 Days 15  
If less than one day hr. min.

9. Birthplace Berwick La 1  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

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

MOTHER FATHER { 12. Name Alfred Benson

13. Birthplace Berwick La 1  
(City, town, or county) (State or foreign country)

14. Maiden name Emma Hanson

15. Birthplace Berwick La 1  
(City, town, or county) (State or foreign country)

16. (a) Informant John W. Griffin

(b) Address P.R. 3 1/2

17. (a) burial (b) Date thereof Aug 14 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Auburn Cem.

18. (a) Signature of funeral director Roy Stamey

(b) Address St. Joseph, Mo

19. (a) Aug 13, 1941 (b) P. G. Nestlebusch  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 12  
year 1941 hour 3 minute A.M.

21. I hereby certify that I attended the deceased from Aug 6-41  
1941 to Aug 12 1941

that I last saw her alive on Aug 12 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Post operative shock Duration 1 day

Due to cholecystectomy Aug 11-41

Due to \_\_\_\_\_

Other conditions 127B  
(Include pregnancy within 3 months of death)

Major findings: gangrenous gall bladder

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature H. W. Kearby M.D. M. D. or other D.M.O.

Address St. Joseph Mo Date signed 8-12-41

EXH 2  
10/11/41

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.....  
Aug 12 1941....., Registered Apprentice No.....  
working under my personal supervision.

Signed John H. Hurley  
Licensed Embalmer No. 4050  
P. O. Address St Joseph M

**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.**