

FILED OCT 18 1941

Registration District No. 001Primary Registration District No. 102Registrar's No. 7184

## 1. PLACE OF DEATH:

- (a) County St. Louis  
 (b) City or town St. Louis  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 1319 N. Sarah  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 (Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_  
 years, months or days

3. (a) PRINT FULL NAME Baty Griffin

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

4. Sex Male  
 5. Color or race Negro  
 6. (a) Single, widowed, married, divorced \_\_\_\_\_  
 6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) Age of husband or wife if \_\_\_\_\_

7. Birth date of deceased September 4th 1941  
 (Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_  
 If less than one day \_\_\_\_\_ hr. 30 min.

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

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

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

- MOTHER FATHER {  
 12. Name Don Griffin  
 13. Birthplace Ludlow, Kentucky  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Grady (Wings)  
 15. Birthplace Joplin City, Missouri  
 (City, town, or county) (State or foreign country)  
 16. (a) Informant Oscar William Johnson, M.D.  
 (b) Address 1046a N. Grand Street  
 17. (a) burial (b) Date thereof 9-25-41  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation CITY CEMETERY  
 18. (a) Signature of funeral director James Hamlet  
 (b) Address City Health Dept.  
 19. (a) 9-4-41 (b) \_\_\_\_\_  
 (Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town St. Louis \_\_\_\_\_  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 1319 N. Sarah \_\_\_\_\_  
 (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 4th  
 year 1941 hour \_\_\_\_\_ minute 2:35 P.M.

21. I hereby certify that I attended the deceased from September 4th 1941 to September 4th 1941; that I last saw him alive on September - 4th - 1941 and that death occurred on the date and hour stated above.

Immediate cause of death bronchial debility of the newborn Duration 300 min - utero

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

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

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) \_\_\_\_\_  
 (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 Oscar William Johnson (M. D. or other) \_\_\_\_\_  
 Address 1046a N. Grand Street Date signed 9-4-41

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**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.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 29845

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. ....

1. PLACE OF DEATH:

(a) County.....  
(b) City or town. St. Louis  
(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.....  
years, months or days)

3. (a) PRINT FULL NAME Baby Griffin

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

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

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

7. Birth date of deceased Sept 4 1941  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
4 12 12 45 min.

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

10. Usual occupation.....

11. Industry of business.....

MOTHER FATHER { 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) (Burial, cremation, or removal) (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

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

(b) Address.....  
19. (a) NOV 21 1941 (b) J. F. Bredeek  
(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) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 4  
year 1941 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....  
that I last saw him/her alive on..... 19.....  
and that death occurred on the date and hour stated above.  
Immediate cause of death.....

Duration

Due to.....  
Due to.....

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).....  
(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..... (M. D. or other).....  
Address..... Date signed.....

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

SUPPLEMENTARY

