

No. 2
1-4-41
5-17
4-90

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 41737
Registrar's No. 126

JAN 9 1942 272

Primary Registration District No. 5379

1. PLACE OF DEATH:
(a) County Douglas
(b) City or town Ava, Benton
(c) Name of hospital or institution: 1
(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

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Douglas 34
(c) City or town Ava Route 2 0
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location) R. 2
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Elbert Giffin
3. (b) If veteran, name war _____
3. (c) Social Security No. 568-05-9451

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Nancy Giffin 6. (c) Age of husband or wife if alive 26 years
7. Birth date of deceased Dec. 28 1912
(Month) (Day) (Year)

8. AGE: Years 28 Months 11 Days 21 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farming and Milk route

11. Industry or business _____

12. Name Chas. Giffin

13. Birthplace Missouri (City, town, or county) (State or foreign country) 0

14. Maiden name Martha Wallace (City, town, or county) (State or foreign country)

15. Birthplace Missouri (City, town, or county) (State or foreign country) 0

16. (a) Informant Dora Hall

(b) Address R 2 Ava, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-21-41 (Month) (Day) (Year)

(c) Place: burial or cremation Dyer

18. (a) Signature of funeral director Clinkingbeard Funeral Home

(b) Address Ava, Missouri

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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec. day 19 year 1941 hour 8 minute 45 P. M.
21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____
that I last saw him _____ alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage into Left Chest Duration 15 min

Due to Gundshot wound

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations 166

Of autopsy _____

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

(a) Accident, suicide, or homicide (specify) None

(b) Date of occurrence 12-19-1941

(c) Where did injury occur? Ava, Mo. (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. C. Gentry (M. D. or other) 0

Address Ava Mo Date signed 12-30-41

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

MOTHER FATHER

1056

Dr. M. C. Gentry

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.....

W. B. Hutchison

Licensed Embalmer No.....

3431

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. 41737

Registration District No. 272

Primary Registration District No. 5379

Registrar's No. _____

1. PLACE OF DEATH: Douglas Ave

(a) County _____

(b) City or town _____
(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 Albert 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 m

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

7. Birth date of deceased Dec 28 1923
(Month) (Day) (Year)

8. AGE: Years 28 Months 11 Days 27 If less than one day _____ 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 12-30-41 (b) Thomas S. Waters
(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 Dec day _____
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 _____

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) _____

(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 _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

MOTHER FATHER

S-41737