

SEP 25 1943
Registration District No. 209

Primary Registration District No. 3043

1. PLACE OF DEATH:
(a) County Marion
(b) City or town Hannibal
(c) Name of hospital or institution:
St. Elizabeth Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day
In this community 1 day
years, months or days (Specify whether)

3. (a) PRINT FULL NAME David Eugene Griffen
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race W 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 March 6 1943
(Month) (Day) (Year)

8. AGE: Years _____ Months 4 Days 18 hr. _____ min. If less than one day

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

10. Usual occupation _____
11. Industry or business _____

MOTHER FATHER
12. Name David Griffen
13. Birthplace Ralls Co Mo
(City, town, or county) (State or foreign country)
14. Maiden name Virginia Rhodes
15. Birthplace Center Mo
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature David Griffen
(b) Address Center Mo

17. (a) Burial (b) Date thereof 7-25-43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St. Pauls Cemetery

18. (a) Signature of funeral director James Hulse
(b) Address Center Mo

19. (a) July 31 1943 (b) P. W. Connor
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Ralls
(c) City or town Center
(If outside city or town limits, write "RURAL")
(d) Street No. R F D (If rural, give location)
(e) If foreign born, how long in U. S. A. 1 years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 24
year 1943 hour 9 minute 30a M.

21. I hereby certify that I attended the deceased from July 23 to July 24, 1943
that I last saw him alive on July 24, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death: Cardiac Decompensation Duration 1 Day
Due to Acute Virus Bronchial Pneumonia 253 Days
Due to _____

Other conditions (include pregnancy within 3 months of death) 109

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 J. P. Dultman (M. D. or other) MD
Address 115 N 5 Hannibal Mo Date signed 7/28/43

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.

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 G. J. Hulen

Licensed Embalmer No. 3356

P. O. Address Center

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.