V. S. No. 2
50M—5-42
ev. 5-17-39
P I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 13 1944

Registration District No. 43

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 41785

Primary Registration District No. 3007

Registrar's No. 366

1. PLACE OF DEATH:

(a) County: Butler

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

(c) Name of hospital or institution: Poplar Bluff Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 4 hrs (Specify whether Hours years, months or days)

In this community:

2. USUAL RESIDENCE OF DEACESED:

(a) State: Missouri (b) County: Stoddard

(c) City or town: Bloomfield, Rural
(If outside city or town limits, write "RURAL")

(d) Street No.:
(If rural, give location)

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

If yes, name country:

3. (a) PRINT FULL NAME: Bill Don Griffin

3. (b) If veteran, name war: --

3. (c) Social Security No.:

4. Sex: Male

5. Color or race: White

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: May (Month) 8 (Day) 1940 (Year)

8. AGE: Years 3 Months 7 Days 11 If less than one day hr. min.

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

10. Usual occupation: --

11. Industry or business:

FATHER 12. Name: Lester Griffin

13. Birthplace: (City, town, or county) (State or foreign country) Mo.

MOTHER 14. Maiden name: Grace Cooper

15. Birthplace: (City, town, or county) (State or foreign country) Mo.

16. (a) Informant: Lester Griffin

(b) Address: Bloomfield, Mo. R. # 1

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12-19-43 (Month) (Day) (Year)

(c) Place: burial or cremation: Gravel Hill Cem.

18. (a) Signature of funeral director: Chiles Und. Co.

(b) Address: Bloomfield, Mo.

19. (a) 12-22-43 (Date received local registrar) (b) Bell Kinne (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Dec. day: 17th year: 1943 hour: 4 minute: p. M.

21. I hereby certify that I attended the deceased from 12-17, 1943, to 12-17, 1943 that I last saw him alive on 12-17, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death: 3rd degree burns shock

Due to: burns & tapeline

Due to: Colonial Stocking caught fire while cleaning up against

Other conditions: None
(Include pregnancy within 3 months of death)

Duration

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): Accident

(b) Date of occurrence: 12-16-43

(c) Where did injury occur? Home (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)

While at work? — (e) Means of injury: Fire

23. Signature: J. M. Hanchman (M. D. or other) M.D.

Address: Poplar Bluff Mo. Date signed:

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 14-102
Date Filed 1-10-44

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 Leon C. Cooper, ~~Registered Apprentice No.~~, working under my personal supervision.

Signed Leon C. Cooper

Licensed Embalmer No. 4119

P. O. Address Bloomfield, 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.