

DEPARTMENT OF COMMERCE

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

DEPT. OF COMMERCE  
BUREAU OF VITAL STATISTICS  
CENSUS  
FILED MAR 11 1944

Registration District No. 139

Primary Registration District No. 5537

Registrar's No. 10

1. PLACE OF DEATH:

(a) County Holt  
(b) City or town Rural Liberty Twp.  
(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 71 Years. (Specify whether  
In this community 71 Years. (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Holt  
(c) City or town (Rural) Mound City, Liberty Twp.  
(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 Sarah Cathrine Griffith.

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced 2 widowed

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

7. Birth date of deceased July 15th, 1850  
(Month) (Day) (Year)

8. AGE: Years 93 Months 6 Days 16 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation House work.

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

12. Name John Andes.

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

14. Maiden name Glick.

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

16. (a) Informant Mrs. Thos. Cracker

(b) Address Mound City, Mo.

17. (a) Burial (b) Date thereof 2-3-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation North Bethel

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

(b) Address Mound City, Mo.

19. (a) 2-3-44 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 1st, year 1944 hour 4 minute A M.

21. I hereby certify that I attended the deceased from Jan 31 1944 to Feb 1 1944 that I last saw her alive on Jan 31 1944 and that death occurred on the date and hour stated above.

Immediate cause of death [Signature] Duration 3 days

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

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

Other conditions (include pregnancy within 3 months of death) 33a

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? \_\_\_\_\_

(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 [Signature]

23. Signature [Signature] (M. D. or other) \_\_\_\_\_

Address Mound City Date signed 2-3-44

1184

(Licensed Embalmer's Statement on Reverse Side)

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

**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. H. Crawford* .....

Licensed Embalmer No. *1824*

P. O. Address *Mount Airy, N.C.*

**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.**