

FILED SEP 10 1944
2-17

State File No. _____

Registration District No. _____

Primary Registration District No. 5786

Registrar's No. 62

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

1. PLACE OF DEATH:

(a) County Mississippi
(b) City or town Charleston, (rural)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
R# 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community All of Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Miss.
(c) City or town Charleston (rural)
(If outside city or town limits, write "RURAL")
(d) Street No. R#2 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME John Willie Griffin

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

4. Sex M 5. Color or race Colored 6. (a) Single, widowed, married, divorced Infant

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

7. Birth date of deceased April 8th 1944
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 4 6 hr. min.

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

10. Usual occupation Infant

11. Industry or business _____

MOTHER FATHER

12. Name Johnnie Griffin
13. Birthplace West Point Miss.
(City, town, or county) (State or foreign country)
14. Maiden name Lard Mae Griffin
15. Birthplace Luxo Ark.
(City, town, or county) (State or foreign country)

16. (a) Informant Johnnie Griffin
(b) Address R # 2 Charleston, Mo.

17. (a) Burial (b) Date thereof 8-14-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Oak Grove Charleston, Mo.

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

19. (a) 9/11/44 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 14th
year 1944 hour 4 minute A M.

21. I hereby certify that I attended the deceased from 8-13-44 to _____ 19____;
that I last saw him alive on 8-13-1944
and that death occurred on the date and hour stated above.

Immediate cause of death Dehydration
Acute Polio
Due to _____
Due to _____

Duration
2 wks
3 wks

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

Major findings: Of operations _____

119d

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 _____

Signature [Signature] (M. D. or other)
Address 204 S. Chestnut St. Charleston Date signed 8-28-44

RECEIVED

District Health Office No. 2

District File Number 944-1200

Date Filed 9-8-44

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.....

working under my personal supervision.

Registered Apprentice No.

Signed.....

Licensed Embalmer No.

P. O. Address.....

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.

Not embalmed