

FILED SEP 30 1944  
318

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

Registration District No. \_\_\_\_\_

Primary Registration District No. 1003

Registrar's No. 8091

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Homer Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 14 days  
In this community 25 years  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME William Griffin  
3. (b) If veteran, name war None  
3. (c) Social Security No. 494-10-0331

4. Sex Male 5. Color or race Negro  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Bessie  
6. (c) Age of husband or wife if alive 29 years  
7. Birth date of deceased Unavailable Abt. 1904  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
Abt. 40 - - hr. min.

9. Birthplace Argola | Mississippi  
(City, town, or county) (State or foreign country)

10. Usual occupation Garage Attendant

11. Industry or business as above

12. Name Oliver Griffin

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

14. Maiden name Georgia Williams

15. Birthplace Argola | Mississippi  
(City, town, or county) (State or foreign country)

16. (a) Informant Bessie Griffin

(b) Address 4143 Delmar Blvd.

17. (a) Burial (b) Date thereof 9-21-1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cem.

18. (a) Signature of funeral director Chas. J. Gates

(b) Address 4107 Finney Ave.

19. (a) SEP 21 1944 (b) J. Bredek  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County St. Louis  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4143 Delmar  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 16,  
year 1944 hour 11 minute 05 P. M.

21. I hereby certify that I attended the deceased from September  
2, 1944 to September 16, 1944

that I last saw him alive on September 16, 1944,  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 15 days

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

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

Other conditions (Include pregnancy within 3 months of death)

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 Alvin Massee (M. D. or other) \_\_\_\_\_

Address 2601 W. Kathleen Date signed 9/18/44

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

MOTHER FATHER

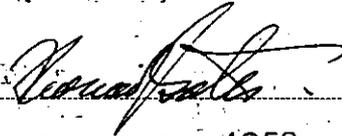
**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by ~~XXXXXX~~

Thomas J. Gates

~~XXXXXXXXXXXX~~, Registered Apprentice No.

~~XXXXXXXXXXXXXXXXXXXX~~  
Signed



Licensed Embalmer No. 4259

P. O. Address 4107 Finney Ave.

**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.**