

FILED FEB 6 1945

Registration District No. **149**

Primary Registration District No. **1002**

18
328

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

1. PLACE OF DEATH:
 (a) County **Jackson,**
 (b) City or town **Kansas City,**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Research Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **10 days**
(Specify whether years, months or days) **as above**

3. (a) PRINT FULL NAME **William P. Griffin,**
3. (b) If veteran, name war **no.**
3. (c) Social Security No. **718-14-3769**

4. Sex **Male** **5. Color or race** **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Mary Myrtle Griffin**
6. (c) Age of husband or wife if alive **unknown** years
7. Birth date of deceased. **March 4 1887**
(Month) (Day) (Year)

8. AGE: Years **57** Months **10** Days **14**
 If less than one day **hr.** **min.**

9. Birthplace **Missouri**
(City, town, or county) (State or foreign country)
10. Usual occupation **Railroad Engineer**

11. Industry or business **R. R.**

MOTHER FATHER
12. Name **William P. Griffin**
13. Birthplace **Indiana**
(City, town, or county) (State or foreign country)
14. Maiden name **Mattie Wolfenberg**
(City, town, or county) (State or foreign country)
15. Birthplace **Indiana**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Mary Myrtle Griffin,**
(b) Address **307 S. 8th St., Chickasha, Oklahoma**
17. (a) Removal **(b) Date thereof** **1-18-45**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Chickasha, Oklahoma,**

18. (a) Signature of funeral director **Stine & McClure,**
(b) Address **3235 Gillham Plaza, K. C., Mo.**
19. (a) 1-18-45 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Oklahoma** (b) County **999**
Chickasha, **34**
(If outside city or town limits, write "RURAL")
 (d) Street No. **807 South 8th Street,** **0**
(If rural, give location)
 (e) Citizen of foreign country? **X** (Yes or No)
 If yes, name country **X** **2**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **January** day **18th**
 year **1945** hour **12:10** minute **P.** M.
21. I hereby certify that I attended the deceased from **January 8,**
1945, to **January 18, 1945,**
 that I last saw him alive on **January 18, 1945,**
 and that death occurred on the date and hour stated above.

Immediate cause of death
Gangrene of the lung following pulmonary infarction **3 weeks**
Prostatectomy **5 weeks**
Diphtheria mellitus **2 years**
Subacute pyelo-nephritis **5 weeks**
Cardiac decompensation **3 weeks**
 Other conditions **with chronic myocarditis**
(Include pregnancy within 3 months of death)

Major findings: **Hypertrophic prostatic**
 Of operations: **61**
 Of autopsy: **61**

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)
 (c) Means of Injury **M.D.**
23. Signature **Gabon Asher** (M. D. or other) **M.D.**
 Address **1210 Poppley** Date signed **1-18-45**

Dr. Graham Asher, Prof. Bldg.

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.....

Licensed Embalmer No. 1412

P. O. Address H C M J

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.