

U. S. No. 2  
DM-5-43  
Rev. 5-17-39  
P. 1 X36671

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

5166

State File No. ....

FILED MAR 3 1945  
1949

Registration District No. ....

Primary Registration District No. 1002

Registrar's No. 742

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:  
General Hospital No. 2  
(If not in hospital of institution, write street number or location)

(d) Length of stay: In hospital or institution 2-1-45- 2-9-45  
18 Yrs  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")

(d) Street No. 1422 E. 18th St.  
(If rural, give location)  
No

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

If yes, name country 0

3. (a) PRINT FULL NAME ARTHUR GRIFFIN

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or race Negro

6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife Ada Griffin

6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased January 27 1885  
(Month) (Day) (Year)

8. AGE: Years 60 Months 00 Days 13

If less than one day hr. min.

9. Birthplace Springfield Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business

12. Name Arthur Griffin

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

14. Maiden name Unknown

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

16. (a) Informant Record Clerk

(b) Address Gen. Hosp. # 2

17. (a) burial (Burial, cremation, or removal)

(b) Date thereof 2/14/45  
(Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Cemetery

18. (a) Signature of funeral director Hatkins Bros

(b) Address 1729 Lydia

19. (a) 1-14-45 (Date received local registrar)

(b) D. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 9 year 1945 hour 11:35 minute 4 M.

21. I hereby certify that I attended the deceased from February 1, 1945, to February 9, 1945 that I last saw him alive on February 9, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Cachexia

Due to Adeno-carcinoma of Stomach

Due to 46 to

Other conditions 46 to  
(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)

Means of injury 0

23. Signature D. E. Brown (M. D. or other)

Address Gen. Hosp. #2-608 E. 22 Date signed 2-13-45

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

MOYER 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 me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*D. J. Malone*

Licensed Embalmer No. *3994*

P. O. Address *2523 Brighton*

**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.**