

No. 2  
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-5-17-39  
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THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **30082**

**FILED OCT 1 1945**  
Registration District No. **2.0**

Primary Registration District No. **3006**

Registrar's No. **246**

1. PLACE OF DEATH:

(a) County **Boone**  
(b) City or town **Columbia**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**Wilhite Convalescent Home 4**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME **C.D. GRISWOLD**  
3. (b) If veteran, name war: \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **Male** 5. Color or race **White**  
6. (a) Single, widowed, married, divorced **9**  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years  
7. Birth date of deceased **9 - 1 - 1877**  
(Month) (Day) (Year)

8. AGE: Years **68** Months **0** Days **19** If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace **Carroll County Illinois**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Railroad Conductor**

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

MOTHER FATHER

12. Name **John Griswold**  
13. Birthplace **Carroll County Illinois**  
(City, town, or county) (State or foreign country)

14. Maiden name **Sarah E. Smith**  
15. Birthplace **Carroll County Illinois**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Wilhite Convalescent Home**  
(b) Address **Columbia, Mo.**

17. (a) **Burial** (b) Date thereof **9-24-45**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Columbia Cemetery**

18. (a) Signature of funeral director **Baron Funeral Home**  
(b) Address **Columbia, Mo.**

19. (a) **9-22-45** (b) **Mrs R.E. Palmer**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Boone 10**  
(c) City or town **Columbia 2**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **104 Ripley St. 4**  
(If rural, give location) \_\_\_\_\_  
(e) Citizen of foreign country? **No** (Yes or No) \_\_\_\_\_  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **20**  
year **1945** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from **8 - 24**  
**1945** to **9 - 20 - 1945**  
that I last saw h. **alive on 9-19-** **1945**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma**  
**Rectal, Abdominal**  
**Rectal** Duration **2 yrs.**

Due to **Operated at Carver Hosp.**

Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: **Carcinoma**  
Of operations \_\_\_\_\_

Of autopsy **None**

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? **No** (Specify type of place) \_\_\_\_\_  
(e) Means of injury \_\_\_\_\_

23. Signature **W. R. ...** (M. D. or other) \_\_\_\_\_  
Address **Columbia, Mo.** Date signed **9-24-45**

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

*Thas L. Lanning*

Licensed Embalmer No.

*41327*

P.O. Address

*Columbia Md*

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. act  
Registrar's No. 246

Registration District No. 38

Primary Registration District No. 3006

1. PLACE OF DEATH:

(a) County Boone  
(b) City or town Columbia  
(If outside city or town limits, write "RURAL" and name of township)  
(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 \_\_\_\_\_ (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME (G D) Griswold

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced (W.D.)

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

7. Birth date of deceased Sept (Month) 15 (Day) 1901 (Year)

8. AGE: Years 68 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or Business \_\_\_\_\_

MOTHER FATHER

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

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

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day \_\_\_\_\_ year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration

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

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

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