V. S. No. 2
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Rev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 2 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31921 8892

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

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9

1. PLACE OF DEATH:
(a) County: St. Louis
(b) City or town: (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: De Paul Hospital 0
(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)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: 000
(c) City or town: St. Louis 17/9
(If outside city or town limits, write "RURAL")
(d) Street No.: 4392a McPherson Ave. 9
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Earl Griffiths
3. (b) If veteran, name war: Nil
3. (c) Social Security No.: 489-10-0037
4. Sex: Male 0
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Mable Griffiths
6. (c) Age of husband or wife if alive: 45 years
7. Birth date of deceased: March (Month) 5 (Day) 1896 (Year)

8. AGE:

Years	Months	Days	If less than one day
49	7	8	hr. min.

9. Birthplace: Denny (City, town, or county) Arkansas (State or foreign country)
10. Usual occupation: Chauffeur
11. Industry or business:
FATHER 12. Name: Daniel Griffiths
13. Birthplace: Unknown (City, town, or county) Wales (State or foreign country)
MOTHER 14. Maiden name: Eva Griffiths
15. Birthplace: Jackson County (City, town, or county) Illinois (State or foreign country)
16. (a) Informant: Mrs. Mable Griffiths
(b) Address: 4392a McPherson Ave.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 10-15-45 (Month) (Day) (Year)
(c) Place: burial or cremation: Percy, Illinois
18. (a) Signature of funeral director: Albert H. Hoppe
(b) Address: 4700 Washington Blvd.
19. (a) OCT 15 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 13 year 1945 hour 4 minute 30 A.M.
21. I hereby certify that I attended the deceased from Oct 5, 1945, to Oct 13, 1945; that I last saw him alive on Oct 12, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Occlusion — Duration: 7 days
Due to:
Due to:
Other conditions (Include pregnancy within 3 months of death): NK
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? (Specify type of place)
While at work? (e) Means of injury:
23. Signature: Robert J. Farrell (M. D. or other)
Address: 624 N. Union Date signed: 10/17/45

(Licensed Embalmer's Statement on Reverse Side)

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 John Agonoski

Licensed Embalmer No. 3398

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.