

FILED JAN 8 1946

Registration District No. _____

Primary Registration District No. 1000

Registrar's No. 1354

1. PLACE OF DEATH:

(a) County Buchanan
 (b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Geiger Apt's., 7th. & Faraon St.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution None
(Specify whether
 In this community 42 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan //
 (c) City or town St. Joseph //
(If outside city or town limits, write "RURAL")
 (d) Street No. Geiger Apt's., 7th. & Faraon.
(If rural, give location)
 (e) Citizen of foreign country? No. (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Frances Agusta Griswold

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Carl J. 6. (c) Age of husband or wife if alive years

7. Birth date of deceased November 25 1877
(Month) (Day) (Year)

8. AGE: Years 68 Months 0 Days 17 If less than one day
hr. min.

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

10. Usual occupation Housewife

11. Industry or business None

12. Name Dr. M. A. Glennan

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

14. Maiden name Alice Reynolds

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

16. (a) Informant Mr. Glenn G. Griswold

(b) Address Geiger Apt's., 7th. & Faraon

17. (a) Burial (b) Date thereof Dec. 15, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Auburn Cemetery

18. (a) Signature of funeral director Herman W. Stogdole

(b) Address 1802 Union St. St. Joseph, Mo.

19. (a) Dec. 26, 1945 (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 12
 year 1945 hour 9 minute 45 P.M.

21. I hereby certify that I attended the deceased from _____, 1945, to Dec 12, 1945;
 that I last saw he alive on Dec 12 - 45, 1945;
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 1 hr
 Due to Arterio Sclerosis 3 hr

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

Major findings: Of operations (S.D.) Of autopsy _____
 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? _____

23. Signature J. H. Allman (M. D. or other) md
 Address Central Ave., ST. JOSEPH Date signed 12/13/45

MOTHER FATHER

1828

JUL 8 1948

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

Blmer Thomas

Registered Apprentice No.

working under my personal supervision.

Signed

Blmer Thomas

Licensed Embalmer No.

2640

P. O. Address

St Joseph

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.