

No. 2
-8-43
-17-39
X37623

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **2889**

FILED JAN 25 1946
Registration District No. **108**

Primary Registration District No. **4219**

Registrar's No. **21**

1. PLACE OF DEATH:

(a) County **Highway**
(b) City or town **Waubesaun**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **20 years** years, months or days

3. (a) PRINT FULL NAME **Thomas A Griffin**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **20**

4. Sex **Males** 5: Color or race **w** 6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Bettie Griffin** 6. (c) Age of husband or wife if alive **84** years
7. Birth date of deceased **Feb 16 1857** (Month) (Day) (Year)

8. AGE: Years **88** Months **10** Days **12** If less than one day hr. min.

9. Birthplace **Rolph County Mo** (City, town, or county) (State or foreign country)

10. Usual occupation **Retired**

11. Industry or business _____

12. Name **Samuel Griffin**

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

14. Maiden name **Wakurin**

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

16. (a) Informant **Susan Lovett**

(b) Address **Waubesaun, Mo**

17. (a) **Burial** (b) Date thereof **12-30-45** (Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (c) Signature of funeral director **Walter Kethaway**

(b) Address **Waubesaun Mo**

19. (a) **Jan 10-46** (b) **W.P. Hargiss** (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Nickay 43**
(c) City or town **Waubesaun** (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 **Dec** day **28** year **1945** hour **6** minute **30** M.

21. I hereby certify that I attended the deceased from **June 19 1940** to **Dec 28 1945** that I last saw him alive on **Dec 27 1945** and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial Failure**
Due to **Bronchial Asthma**

Due to _____

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

Major findings: Of operations _____

Of autopsy **112**

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 **H R Easton** (M. D. or other) **MD**

Address **Waubesaun Mo** Date signed **Jan 10, 1946**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

1055

7,
12-45-1386
1-22-46

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 *Chas Gilbert Hathaway*

Licensed Embalmer No. *4267*

P. O. Address *Wheatland, 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.