

Registration District No. **317**

Primary Registration District No. **2002 3069**

Registrar's No. **3256**

**1. PLACE OF DEATH:**

(a) County St. Louis  
(b) City or town University City Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Marys Hospital C  
(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 Mo (b) County St. Louis  
(c) City or town University City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 7016 Westmoreland  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME**

CARMAN GRIFFIN

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex MO 5. Color or race W

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

6. (b) Name of husband or wife GEORGIA GRIFFIN

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

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) 1881 (Year)

8. AGE: Years 65 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace St. Louis Mo (City, town, or county) (State or foreign country)

10. Usual occupation Salesman

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

12. Name Henry Griffin

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

14. Maiden name Unknown

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

16. (a) Informant Shirley Griffin

(b) Address 7016 Westmoreland

17. (a) burial (b) Date thereof 11-9-46 (Month) (Day) (Year)

(c) Place: burial or cremation Cabary Cemetery

18. (a) Signature of funeral director Harrold Shaban

(b) Address 4415 Washington Bl

19. (a) 11-9-46 (Date received local registrar) (b) Arthur J. Allen (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 11 - day 8 year 1946 hour 4 minute 30 A. M.

21. I hereby certify that I attended the deceased from 5-24, 1943 to 11-8, 1946.  
that I last saw him alive on 11-7, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage  
Due to Hypertensive vascular disease  
Due to 830

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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) \_\_\_\_\_ (Specify type of injury)  
Signature Dr. J. H. Kelly (M. D. or other) \_\_\_\_\_  
Address 118-46 Date signed 11-8-46

Duration \_\_\_\_\_  
**PHYSICIAN**  
Underline the cause to which death should be charged statistically.

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

30500

**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 S. Demme*.....  
Licensed Embalmer No..... *4194*.....  
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.**