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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED MAR 24 1947  
318

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

1003

Registrar's No. 2627

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
 (b) City or town St. Louis  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
The City Infirmary Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution April 2, 1945..  
March 11, 1947.. (Specify whether  
 In this community \_\_\_\_\_  
 years, months or days)

3. (a) PRINT FULL NAME GRIFFIN, CLARENCE

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

4. Sex Male 5. Color or race Col. 6. (a) Single, widowed, married, divorced Widower

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

7. Birth date of deceased July 6, 1891  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>55</u>	<u>8</u>	<u>3</u>	hr. min.

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

10. Usual occupation LABOR

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

12. Name Wilbert Griffin

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

14. Maiden name Rosie Delves

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

16. (a) Informant The City Infirmary Records

(b) Address 5800 Arsenal St.

17. (a) BURIAL (b) Date thereof MAR 18, 1947  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation FATHER DICKSON

18. (a) Signature of general director F. A. GREEN

(b) Address 2513 W. RANKIN

19. (a) MAR 13 1947 (b) J. F. Bredrecht  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County \_\_\_\_\_  
 (c) City or town St. Louis  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 5800 Arsenal St  
 (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 11  
 year 1947 hour 10 minute 50 A.M.

21. I hereby certify that I attended the deceased from April 2, 1945 to March 11, 1947  
 that I last saw him alive on March 11, 1947  
 and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy of Brain

Due to Pulmonary Edema

Due to \_\_\_\_\_

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 \_\_\_\_\_

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 Robert Francis Bowdler (M. D. or other) \_\_\_\_\_

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

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

MOTHER FATHER

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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

*J. A. Green*

Licensed Embalmer No.

*2963*

P. O. Address

*2915 Franklin*

**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.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. April 7Registration District No. 318Primary Registration District No. 1003Registrar's No. 2627

## 1. PLACE OF DEATH:

- (a) County.....  
 (b) City or town..... ST. LOUIS  
 (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

In this community.....  
years, months or days)

## 3. (a) PRINT FULL NAME

Clarence Huffin3. (b) If veteran,  
name war.....3. (c) Social Security  
No.....4. Sex..... m 5. Color or race..... B

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if

7. Birth date of deceased..... July 6 1899  
(Month) (Day) (Year)8. AGE: Years Months Days  
55 8 18 If less than one day  
hr. min.9. Birthplace..... Key  
(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) (Burial, cremation, or removal) (b) Date thereof.....  
(Month) (Day) (Year)

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) 3-13-1947 (b) J. J. Bruce  
(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..... March  
year..... 1947 hour..... minute..... M.21. I hereby certify that I attended the deceased from.....  
to....., 19.....  
that I last saw him..... alive on....., 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 sta-  
tistically.

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)  
(c) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

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

SUPPLEMENTARY

S-10903