

**FILED OCT 4 1947**

Registration District No. **38**

Primary Registration District No. **3006**

Registrar's No. **251**

**1. PLACE OF DEATH:**

(a) County **Boone**

(b) City or town **Columbia**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
**905 north 3rd st**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **45 yr** (Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Missouri** (b) County **Boone** **10**

(c) City or town **Columbia** **2**  
(If outside city or town limits, write "RURAL")

(d) Street No. **905 N 3rd St** **4**  
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)

If yes, name country **X**

**3. (a) PRINT FULL NAME** **Amandus S. Griggs**

3. (b) If veteran, name war **X**

3. (c) Social Security No. **X**

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **Sept** day **22** year **1947** hour **2:45** minute **A** M.

21. I hereby certify that I attended the deceased from **4 years** 19... to 19...; that I last saw him **alive on** and that death occurred on **the** date and hour stated above.

4. Sex **M** 5. Color or race **W**

6. (a) Single, widowed, married, divorced **W**

6. (b) Name of husband or wife **Mary Elizabeth Griggs** 6. (c) Age of husband or wife if **Dead** years

7. Birth date of deceased **-8-Aug 8 1856**  
(Month) (Day) (Year)

Immediate cause of death **Coronary block** **94X**

Due to **Age**

Due to **Arteriosclerosis**

Other condition (Include pregnancy **94X** months of death)

**8. AGE:** Years **91** Months **1** Days **14** If less than one day hr. min.

9. Birthplace **Callaway Co Mo**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business **"**

MOTHER FATHER

12. Name **Ambrose Griggs Jr**

13. Birthplace **unknown**  
(State or foreign country)

14. Maiden name **Bythina Sallie**

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

16. (a) Informant **Mrs C A Frost**

(b) Address **905 N 3rd Columbia Mo**

17. (a) **Burial** (b) Date thereof **Sept 24-47**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Centralia Cem.**

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

(b) Address **Columbia**

19. (a) **9-23-47** (b) **Mrs P E Palmer**  
(Date received local registrar) (Registrar's signature)

Major findings: **none**

Of operations **none**

Of autopsy **none**

**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) **No**

(b) Date of occurrence **No**

(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? **No** (Specify type of place) (e) Means of injury **0**

23. Signature **W. P. Hiant** (M. D. or other) **M.D.**

Address **Columbia Mo** Date signed **9-23-47**

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

2  
4

35074

RECEIVED  
District Health Officer No. 9,  
District File Number  
16-3-47 Filed

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, ~~\_\_\_\_\_~~  
~~\_\_\_\_\_~~, Registered, Apprentice No. ~~\_\_\_\_\_~~  
working under my personal supervision.

Signed Lynnan W Sprinkle  
Licensed Embalmer No. 4013  
P. O. Address Columbia, Mo

**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.**