

No. 2  
1/47  
17-39

FILED SEP 2 1948  
Registration District No. **82**

Primary Registration District No. **3017**

Registrar's No. **104**

1. PLACE OF DEATH:

(a) County **COOPER**

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

(c) Name of hospital or institution: **ST. JOSEPH HOSPITAL**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **2 HRS** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **COOPER** **27**

(c) City or town **otterville** **0**  
(If outside city or town limits, write "RURAL") **0**

(d) Street No. **0**  
(If rural, give location)

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

If yes, name country

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

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

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

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Widow**

6. (b) Name of husband or wife **George E Griffin** 6. (c) Age of husband or wife if alive, years **70**

7. Birth date of deceased **July 22 1872**  
(Month) (Day) (Year)

8. AGE: Years **76** Months **0** Days **26** If less than one day **br. min.**

9. Birthplace **otterville MO**  
(City, town, or county) (State or foreign country)

10. Usual occupation **House Keeper**

11. Industry or business **Home**

12. Name **G. Cline**

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

14. Maiden name **Stark**

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

16. (a) Informant **Mrs Wm J. Lamm**

(b) Address **Sedalia, MO**

17. (a) **Smithton, MO** (b) Date thereof **8/17/48**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Smithton, MO**

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

(b) Address **Boonville, MO**

19. (a) **8-18-48** (b) **Stagner**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **17**  
year **1948** hour **5:30** minute **P** M.

21. I hereby certify that I attended the deceased from **Aug 17 1948** to **Aug 17 1948**  
that I last saw her alive on **Aug 17 1948**  
and that death occurred on the date and hour stated above.

Immediate cause of death **BRAIN INJURY SKULL FRACTURE**

Due to **70%**

Due to **10%**

Other conditions (Include pregnancy within 3 months of death) **10%**

Major findings: Of operations **none**

Of autopsy **none**

Duration

PHYSICIAN

Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **acc. dent**

(b) Date of occurrence **Aug 17, 1948** **27**

(c) Where did injury occur? **RFD Cooper, MO**  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **State Highway # 2**  
(Specify type of place)

While at work? **car collision** (e) Means of injury

23. Signature **T.C. Beckett MD** (acting coroner)

Address **Boonville, MO** Date signed **8-17-48**

Call with other vehicles

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

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 9-1-48

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 \_\_\_\_\_

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

Signed \_\_\_\_\_

Licensed Embalmer No. 3780

P. O. Address Boonville, 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.