

No. 2  
5-17-43  
I X36671

FILED NOV 4 1948

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

4192

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:  
2905 Campbell, Campbell Nursing Home  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 1/2 Years 4  
In this community 48 Years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")

(d) Street No. 2905 Campbell  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Fannie May Griffin

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Widow 2

6. (b) Name of husband or wife Henry Griffin

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

7. Birth date of deceased 5 3 1865  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

83 Years 5 9 hr. min.

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

10. Usual occupation At Home

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

12. Name William Miles

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

14. Maiden name No Record

15. Birthplace No Record  
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Elmer M. Griffin

(b) Address 1705 Summitt

17. (a) Burial (b) Date thereof 10-15-1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah

18. (a) Signature of funeral director Mrs. C. L. Forster

(b) Address Kansas City, Mo.

19. (a) 10-15-48 (b) Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 12th.  
year 1948 hour 10 minute 30 P. M.

21. I hereby certify that I attended the deceased from Sept 10, 1948, to October 7, 1948  
that I last saw her alive on October 7, 1948, and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial failure Duration \_\_\_\_\_

Due to General Arteriosclerosis  
Chronic Myocarditis

Due to Arteritis Deformans

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings:  
Of operations \_\_\_\_\_

Of autopsy No

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) \_\_\_\_\_

(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 Edward C. Teubel

23. Signature Edward C. Teubel (M. D. or other) \_\_\_\_\_  
Address 4304 Troost Date signed Oct 14/48

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

MOTHER FATHER

Argyle Bldg.

Fe 49 24

4304 Stewart St  
5-30

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 Dean Owens

Licensed Embalmer No. 4280

P. O. Address Rt. 1, 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.**