

FILED APR 1 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10100

State File No. 2711
Registrar's No. 1003

REG. DIST. NO. 318 PRIMARY REG. DIST. NO.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3467 Macklind Ave. 1		d. STREET ADDRESS (If rural, give location) 3467 Macklind Ave. 01	
3. NAME OF DECEASED (Type or Print) a. (First) MARIE b. (Middle) J. c. (Last) GRIFFIN (CLARK)		4. DATE OF DEATH (Month) (Day) (Year) Mar. 25 1949	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 21, 1896
9. AGE (In years last birthday) 52		10. UNDER 1 YEAR Months 10 Days 4	11. UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis, Mo. 0
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME William Duncan	
13b. MOTHER'S MAIDEN NAME Mary Schumann		14. NAME OF HUSBAND OR WIFE Michael J. Griffin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Michael J. Griffin		ADDRESS 3467 Macklind Av.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Paralysis (apoplexy) ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio Sclerosis DUE TO (c) 0 II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Myocarditis	
INTERVAL BETWEEN ONSET AND DEATH 3 days 4 yrs + 4 yrs T		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan 2, 1945, to Mar 25, 1949, that I last saw the deceased alive on Mar 24, 1949, and that death occurred at 3:30A m., from the causes and on the date stated above.			
23a. SIGNATURE Arthur P. Smith		23b. ADDRESS 5203 Chiffawa St.	
23c. DATE SIGNED 3/25/49		23d. DEGREE OR TITLE M.D.	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Mar. 28, 1949	
24c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.	
DATE REC'D BY LOCAL REG. MAR 28 1949		REGISTRAR'S SIGNATURE J. B. Sasser	
25. FUNERAL DIRECTOR'S SIGNATURE Kriegshauser		ADDRESS 4228 S. Kingshighway Bl.	

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

11-4
Stovesand

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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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Richard W. Stovesand

Signed _____
Student Embalmer

Licensed Embalmer No. 4007

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.