

THE DIVISION OF HEALTH OF MISSOURI
FILED JUN 22 1949 STANDARD CERTIFICATE OF DEATH

State File No. 22294

BIRTH NO. REG. DIST. NO. 338 PRIMARY REG. DIST. NO. 4501 Registrar's No. 29

1. PLACE OF DEATH a. COUNTY Stoddard		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Stoddard	
b. CITY (If outside corporate limits, write RURAL and give town) Bloomfield		c. CITY (If outside corporate limits, write RURAL and give township) Dexter	
c. LENGTH OF STAY (In this place) 2 wks.		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION Bloomfield County Home			

3. NAME OF DECEASED a. (First) George		b. (Middle)		c. (Last) Griffith		4. DATE OF DEATH (Month) (Day) (Year) June 10, 1949	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH July 16, 1867	
9. AGE (In years last birthday) 81		IF UNDER 1 YEAR Months 10 Days 25		IF UNDER 1 HRS. Hours Mins. 		11. BIRTHPLACE (State or foreign country) Shelbyville, Ill.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Mary Griffith	
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 Mary Griffith	
				ADDRESS Idalia, Mo.	

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) Chronic Myocarditis		INTERVAL BETWEEN ONSET AND DEATH ?	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		4222	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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)		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 June 1, 1949, to June 6, 1949, that I last saw the deceased alive on June 6, 1949, and that death occurred at 2:25 P.M., from the causes and on the date stated above.

23a. SIGNATURE <i>Dr. Davis</i>		(Degree or title) MD		23b. ADDRESS Bloomfield Mo.		23c. DATE SIGNED June 13, 1949	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 6-12-49		24c. NAME OF CEMETERY OR CREMATORY Dexter Cemetery		24d. LOCATION (City, town, or county) (State) Dexter, Missouri	
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DATE REC'D BY LOCAL REG. 6-17-49		REGISTRAR'S SIGNATURE <i>Rose Webb</i>		25. FUNERAL DIRECTOR'S SIGNATURE Watkins Funeral Ser, Dexter, Mo.		ADDRESS	
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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

13
2
1

103
3
1
0

RECEIVED

District Health Office N

District File Number 6892

Date Filed JUN 20 194

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.

Student
Student Embalmer

Signed

B. Brentlinger

Licensed Embalmer No. *4401*

P. O. Address

Deiter M

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.