

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19876

State File No. _____

FILED JUN 28 1954

BIRTH NO. _____		REG. DIST. NO. <u>274</u>	PRIMARY REG. DIST. NO. <u>3052</u>	Registrar's No. <u>224</u>
1. PLACE OF DEATH a. COUNTY <u>Pettis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>		
b. CITY (If outside corporate limits, write RURAL and give town) <u>Sedalia</u>		c. LENGTH OF STAY (in this place) <u>29 years</u>	c. CITY OR TOWN <u>Sedalia</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1006 West 10th</u>		d. Residence within limits of a city incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>WILLIAM</u>		b. (Middle) <u>NEWTON</u>	c. (Last) <u>GRIFFING</u>	4. DATE OF DEATH (Month) <u>June</u> (Day) <u>16</u> , (Year) <u>1954</u>
5. SEX <u>Male</u> <input type="radio"/>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 17, 1876</u>	9. AGE (In years last birthday) <u>77</u> IF UNDER 1 YEAR Months <u>11</u> IF UNDER 24 HRS. Hours <u>28</u> Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General painting</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Hamilton, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>John C. Griffing</u>		13b. MOTHER'S MAIDEN NAME <u>Frances Ellis</u>	14. NAME OF HUSBAND OR WIFE <u>Clara Schick Griffing</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Spanish American War</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Clara Griffing</u> ADDRESS <u>Sedalia, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) <u>World War I</u>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>APOPLEXY - CEREBRAL</u>		INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u>
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u>		
		DUE TO (b) _____		
		DUE TO (c) _____		
		II. OTHER SIGNIFICANT CONDITIONS <u>MALNUTRITION - LOCOMOTOR ATAXIA</u> <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>		
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) _____ 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 <u>APRIL 1954</u> to <u>DEATH</u> , that I last saw the deceased alive on <u>JUNE 16 1954</u> and that death occurred at <u>9:00 pm</u> from the causes and on the date stated above.				
23a. SIGNATURE <u>Paul B. Gower MD</u> (Degree or title)		23b. ADDRESS <u>Sedalia Mo.</u>		23c. DATE SIGNED <u>18 June 1954</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>June 19, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>	24d. LOCATION (City, town, or county) (State) <u>Sedalia, Missouri</u>
DATE REC'D BY LOCAL REG. _____		REGISTRAR'S SIGNATURE <u>Leanna Boone Dept. Health</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Eugene</u> ADDRESS <u>Sedalia, Mo.</u>	

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

8-121-54

(Enclosed Embalmer's Statement on Reverse Side)

JUN 8

JUL 6 1954

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
Signature of Student Embalmer

Signed *R. E. Baker*

Licensed Embalmer No. *241*

P. O. Address *Secluded*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.