

XC-1674507

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21295

R#-9346

FILED AUG 4 - 1955

State File No. 415
Registrar's No. 415

BIRTH NO. _____ REG. DIST. NO. 43 PRIMARY REG. DIST. NO. 3007

1. PLACE OF DEATH a. COUNTY Butler		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Oregon	
b. CITY OR TOWN Poplar Bluff		c. CITY OR TOWN Thayer	
c. LENGTH OF STAY (in this place) 22 days		d. STREET ADDRESS (If rural, give location) Rural Route #1	
d. FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) Thomas	b. (Middle) Jackson	c. (Last) Griffith	4. DATE OF DEATH (Month) (Day) (Year) July 23, 1955
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 1-6-89	9. AGE (In years last birthday) 66	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant, Retired	10b. KIND OF BUSINESS OR INDUSTRY Merchant	11. BIRTHPLACE (State or foreign country) Pilot, Arkansas	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Riley Griffith	13b. MOTHER'S MAIDEN NAME Ellen Biggers	14. NAME OF HUSBAND OR WIFE Norma Griffith
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	(If yes, give war or dates of service) WW I	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME VA HOSPITAL RECORDS	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 331X		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) VA	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **July 1, 1955, to July 23, 1955**, and that death occurred at **9:05 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) E.D. BASKETT, M.D., Chief, Medical Service, VA Hospital, Poplar Bluff, Mo.	23b. ADDRESS	23c. DATE SIGNED 7-25-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7-26-55	24c. NAME OF CEMETERY OR CREMATORY Pilot Cemetery	24d. LOCATION (City, town, or county) (State) Manassas Spg. Ark
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DATE REC'D BY LOCAL REG. 7/28/55	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE [Signature]	ADDRESS Cartee Funeral Home Thayer Mo
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(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
AUG 2 1955

BUTLER CO. HEALTH CENTER

FILE No. _____

11
AUG 4 1955

8961

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 7-23

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Phil A. Juchel

Licensed Embalmer No. 2936

P. O. Address Maple Bluff W.

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.