

FILED MAR 5 1956

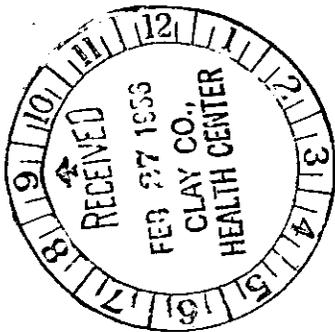
THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4137

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>72</u>		PRIMARY REG. DIST. NO. <u>5289</u>		Registrar's No. <u>15</u>	
1. PLACE OF DEATH a. COUNTY <u>CLAY</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). --a. STATE <u>Mo</u> b. COUNTY <u>CLAY</u>			
b. CITY (If outside corporate limits, write RURAL and give town) <u>Gashland</u>		c. LENGTH OF STAY (In this place) <u>11 Yrs</u>		c. CITY OR TOWN <u>GASHLAND</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>152 HiWAY IMIE 169 HiWAY</u>				e. STREET ADDRESS (If rural, give location) <u>152 HiWAY ON HiWAY 152</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Joseph</u> b. (Middle) <u>Madison</u> c. (Last) <u>GRIFFIS</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 17 1956</u>				
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>SEPT. 20 1886</u>	
9. AGE (In years last birthday) <u>69</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Florist</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>Iowa Point Mo.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13a. FATHER'S NAME <u>JAMES GRIFFIS</u>		13b. MOTHER'S MAIDEN NAME <u>GEORGANN MOORE</u>		14. NAME OF HUSBAND OR WIFE <u>CATHERINE GRIFFIS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>496-01-6616</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>MRS CATHERINE GRIFFIS GASHLAND Mo</u>			
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of Stomach</u> 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.					
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) (Min)	
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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>D. J. Pate M.D. Coroner</u>				23b. ADDRESS <u>3 North Kansas City Mo</u>		23c. DATE SIGNED <u>2/20/56</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremial</u>		24b. DATE <u>Feb 20-56</u>		24c. NAME OF CEMETERY OR CREMATORY <u>White Chapel M.S.</u>		24d. LOCATION (City, town, or county) (State) <u>Clay Co. Mo</u>	
DATE REC'D BY LOCAL REG. <u>2-20-56</u>		REGISTRAR'S SIGNATURE <u>Marquette Hudson</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>D.W. Hancock Iowa N.H.C. Mo.</u>			

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



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.....
John H. Kalsbeek

Licensed Embalmer No. *4949*

P. O. Address *No. Kansas*

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.