

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34405  
STATE FILE NUMBER

FILED OCT 17 1956

Registration District No. 154 Primary Registration District No. 5575 Registrar's No. 68

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <b>Rural Washington Twp.</b> TOWN <b>Hickman Mills</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Curtis Convalescent</b>		Length of stay in lb <b>2 mo</b>	d. STREET ADDRESS (If outside, give location) <b>8604 Independence Ave</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ERVIN</b> Middle <b>GRIFFITH</b> Last <b>GRIFFITH</b>			4. DATE OF DEATH Month <b>Oct</b> Day <b>3</b> Year <b>1956</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 20 1883</b>	9. AGE (In years last birthday) <b>72</b> IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Exide Battery</b>	11. BIRTHPLACE (City and state or country) <b>Linn Co Kansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Edward L Griffith</b>			14. MOTHER'S MAIDEN NAME <b>Eva-Frances-04- Mary Whiteside</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>486-03-3155A</b>	17. INFORMANT Address <b>Robert Griffith New York City New York</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Congestive Heart Failure</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n) <b>Pulmonary Emphysema</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ Month _____ Day _____ a. m. _____ p. m. _____					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY _____ STATE _____
21. I attended the deceased from <b>1947</b> to <b>Oct 3, 1956</b> and last saw her <b>Aug 11, 1956</b> alive on <b>Aug 11, 1956</b> Death occurred at <b>4:30</b> A. m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Do/see or title) <b>Paul G. Johnson MD</b>		22b. ADDRESS <b>5711 Lindber Ave</b>		22c. DATE SIGNED <b>10/3/56</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Oct 5 1956</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt Washington Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City Missouri</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Sheil Funeral Home K C Missouri</b>		25. DATE RECD. BY LOCAL REG. <b>10-4-56</b>	26. REGISTRAR'S SIGNATURE <b>Dwight E. Goddard</b>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

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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..

Student.....  
Signature of Student Embalmer

Signed *Thomas A. Sheel* .....

Licensed Embalmer No. *49*

P. O. Address *J.C.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
(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.