

Health, Welfare, Public Service

FILED OCT 9 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

318880  
STATE FILE NUMBER  
4434

Registration District No. 149 Primary Registration District No. 1002

Registrar's No. 4434

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) <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input 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) <b>Menorah Medical Center</b>			Length of stay in 1b <b>4 1/2 yrs</b>	d. STREET ADDRESS <b>3841 Roberts</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>FRANCES</b> Last <b>Griffith</b>				4. DATE OF DEATH Month <b>September</b> Day <b>22</b> Year <b>1957</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-8-1877</b>		9. AGE (In years) <b>80</b>	IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b>	IF UNDER 24 HRS. Hours <b>—</b> Min. <b>—</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>at Home</b>		11. BIRTHPLACE (City and state or country) <b>English, Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>William Mathis</b>			13b. MOTHER'S MAIDEN NAME <b>Nancy Linton</b>		14. NAME OF HUSBAND OR WIFE <b>Mountford O. Griffith</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>none</b>		17. INFORMANT <b>Wm. F. Griffith 817 W. Oregon St. Kansas City, Mo.</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>Acute pulmonary edema</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>Chronic cardiac decompensation</b>		sev. yrs				
		DUE TO (c) <b>A-S-C-V-disease</b>		4221		sev. yrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Bronchiectasis + pulmonary fibrosis</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <b>—</b> Month, Day, Year <b>—</b> a.m. <b>—</b> p.m. <b>—</b>								
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>1955</b> to <b>9/22/57</b> and last saw her alive on <b>9/22/57</b> Death occurred at <b>3:05</b> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>Walter P. Jacob M.D.</b>			22b. ADDRESS <b>701 E 63 St.</b>		22c. DATE SIGNED <b>9/23/57</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Sept. 25, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>mt. moriah Cemetery</b>		23d. LOCATION (City, town, or county) <b>Kansas City, Mo.</b>		(State)	
24. FUNERAL DIRECTOR <b>C.H. Blackman &amp; Son Inc. K.C. Mo.</b>			ADDRESS	25. DATE RECD. BY LOCAL REG. <b>9-24-57</b>	26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>			

Walter P. Jacob, M.D. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE. MEDICAL CERTIFICATION 6-6-1950



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 *Bert B. Bennett* .....

Licensed Embalmer No. *4656* .....

P. O. Address *H. C. Smith* .....

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.