

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-007282  
STATE FILE NUMBER  
2360

FILED MAR 5 1958

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2360

300  
-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO</b>		c. CITY OR TOWN <b>ST. LOUIS, MO.</b>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>City Hospital #1</b>		d. STREET ADDRESS (If outside, give location) <b>CHRONIC HOSPITAL 5600 Arsenal</b>	
Length of stay in lb		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ralph</b> Middle <b>Griffith</b> Last <b>Griffith</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>30</b> Year <b>1958</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 type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB 26, 1875</b>
9. AGE (In years <i>say</i> birthday) <b>82</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>	11. BIRTHPLACE (City and state or country) <b>IOWA</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13a. FATHER'S NAME <b>JOHN C.</b>		13b. MOTHER'S MAIDEN NAME <b>ADDIE HIPPLE</b>	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	17. INFORMANT Address <b>ST. LOUIS CITY HOSP. #1.</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>Transitional Cell Carcinoma of Urinary Bladder</b>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>181-0</b>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <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>12/9/58</b> to <b>1/30/58</b> and last saw her alive on <b>1/30/58</b> Death occurred at <b>1:05 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Edgar B. Gutter MD</b>		22b. ADDRESS <b>1515 LAFAYETTE AVE.</b>	22c. DATE SIGNED <b>2/3/58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>2-28-58</b>		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board</b>
23d. LOCATION (City, town, or county) <b>St. Louis, Mo.</b>		(State)	
24. FUNERAL DIRECTOR <b>Rowland Aker Mortuary Service</b> 4104 Manchester Ave. St. Louis 10, Mo		25. DATE RECD. BY LOCAL REG. <b>FEB 27 '58</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith MD</b> <i>mgs.</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

**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 .....

Licensed Embalmer No. ....

P. O. Address .....

**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.**