

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-011691  
STATE FILE NUMBER  
3453

FILED APR 3 1958

Registration District No. 318 Primary Registration District No. 1003

Registrar's No.

300  
-57

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWNSHIP ST. LOUIS, MO.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN ST. LOUIS, MO.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 25 ST. LOUIS CUTY HOSP # 1		Length of stay in 1b	d. STREET (If outside, give location) ADDRESS 25 401 FRANKLIN
3. NAME OF DECEASED (Type or print) First Middle Last REX FRANKLIN GRIFFITH			4. DATE OF DEATH Month Day Year FEB. 11, 1958
5. SEX MALE 0	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 99 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 15/1899
9. AGE (In years last birthday) 59		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 ??	11. BIRTHPLACE (City and state or country) SO. CAR.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME FRANK GRIFFITH	
13b. MOTHER'S MAIDEN NAME LUCY HAYES		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) ?????		16. SOCIAL SECURITY NO. ??	17. INFORMANT ST. LOUIS CITY HOSP. #1
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) <u>Dehydration</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
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.)	
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 <u>2/7/58</u> to <u>2/11/58</u> and last saw her alive on <u>2/11/58</u> Death occurred at <u>4:00 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22. SIGNATURE (Degree or title) <u>Doron M Bernstein MD</u>		22b. ADDRESS 1515 LAFAYETTE AVE.	22c. DATE SIGNED 2/11/58
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 3-3-58	23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
24. FUNERAL DIRECTOR ADDRESS Rowland-Aker Mortuary Service 4104 Manchester Ave. St. Louis 10, Mo.		25. DATE RECD. BY LOCAL REG. MAR 26 '58	26. REGISTRAR'S SIGNATURE <u>Carol Smith MD</u> -m83.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be stated. 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.**