

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-018218

STATE FILE NUMBER

FILED JUN 5 1958

Registration District No. 149 Primary Registration District No. 1002

Registrar's No. 2507

S. 300
1-57

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Butler</u>								
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Butler 0076</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Malotte Nursing Home</u>			Length of stay in lb <u>4 years</u>		d. STREET ADDRESS (If outside, give location) <u>X</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>K</u> Last <u>GRIFFIN</u>				4. DATE OF DEATH Month <u>May</u> Day <u>16</u> Year <u>1958</u>								
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 11, 1862</u>		9. AGE (In years last birthday) <u>95</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (City and state or country) <u>Columbia, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13a. FATHER'S NAME <u>James Griffin</u>			13b. MOTHER'S MAIDEN NAME <u>Dolly Shull</u>			14. NAME OF HUSBAND OR WIFE <u>Etta May Griffin</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Gladys Vogel - 5300 Virginia Rd</u> Address <u>5300 Virginia Rd</u>							
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>Arteriosclerosis</u>								INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>				
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>arteriosclerosis</u>		DUE TO (c) <u>4 yrs</u>		DUE TO (c) <u>4500</u>						
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"/>				
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 <u>12 noon</u> Month, Day, Year <u>1-1-58</u> 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 <u>1-1-58</u> to <u>5-16-58</u> and last saw ^{him} alive on <u>5-16-58</u> Death occurred at <u>12 noon</u> on the date stated above; and to the best of my knowledge, from the causes stated.												
22a. SIGNATURE <u>Frank Paul Lauritzen MD</u> (Degree or title)					22b. ADDRESS <u>428 S. White Ave</u>			22c. DATE SIGNED <u>5-16-58</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county) (State)					
<u>burial</u>		<u>May 19 1958</u>		<u>Int. Memorial Cemetery</u>			<u>Kansas City Mo</u>					
24. FUNERAL DIRECTOR <u>Hilbe Funeral Home</u>			ADDRESS <u>2315 Penwood</u>			25. DATE RECD. BY LOCAL REG. <u>5-17-58</u>		26. REGISTRAR'S SIGNATURE <u>Neve Marshall</u>				

(Deceased Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Frank Paul Lauritzen MD

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 *Chas E Weeks*

Licensed Embalmer No. *2644*

P. O. Address *1907MO*

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.