

FILED AUG 1 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-027004
STATE FILE NUMBER

Registration District No. _____

318

Primary Registration District No.

1003

Registrar's No.

7176

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>St. Louis 4,</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>DOA CITY HOSPITAL</u>			Length of stay in 1b <u>5</u>		d. STREET ADDRESS (If outside, give location) <u>2327 Geyer</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LAFAYETTE</u> Middle <u>NMI</u> Last <u>GRIGGS</u>				4. DATE OF DEATH Month <u>July</u> Day <u>20,</u> Year <u>1958</u>						
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>April 1, 1912</u>		9. AGE (In years last birthday) <u>46yrs</u>		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurant Employee</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (City and state or country) <u>Pocahontas, Ark.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>Jake Griggs</u>			13b. MOTHER'S MAIDEN NAME _____			14. NAME OF HUSBAND OR WIFE <u>Albertene Griggs</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>457-24-5727</u>		17. INFORMANT Address <u>Mrs. Albertene Griggs 2327 Geyer (A)</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>Chronic cor pulmonale</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Chronic pulmonary fibrosis & emphysema</u>		DUE TO (c) <u>Chronic pulmonary tuberculosis, FA-Inactive</u>		2 years +		6 1/2 yrs.		
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 <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.) <u>Heart attack</u> <u>7-21-58</u>							
20c. TIME OF INJURY Hour _____ 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 <u>Monet, Ark</u>		STATE	
21. I attended the deceased from <u>Aug. 22, 1950</u> to <u>July 20, 1958</u> and last saw ^{her} him alive on <u>May 24, 1958</u> Death occurred at <u>7:30 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE <u>Ellis S. Lipsitz, M.D.</u>					22b. ADDRESS <u>457 N. Kemphreyway, St. Louis, Mo</u>			22c. DATE SIGNED <u>7/21/58</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>July 20, 1958</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Macey Cemetery</u>			23d. LOCATION (City, town, or county) <u>Monet, Ark</u>		(State)	
24. FUNERAL DIRECTOR <u>Gregg Funeral Home Jonesboro Ark</u>					25. DATE RECD. BY LOCAL REG. <u>JUL 21 '58</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u> <u>mjb.</u>			

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 *Jos. E. McCulloch*
Licensed Embalmer No. *246*
P. O. Address *6175 Dalm*

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.