

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-032702  
STATE FILE NUMBER 4181

FILED SEP 24 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

300  
1-57

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) OR TOWN <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) HOSPITAL OR INSTITUTION <b>General Hospital #1</b>		Length of stay in 1b <b>60 YEARS</b>	d. STREET ADDRESS (If outside, give location) <b>1231 Jefferson</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Mattie</b> Middle <b>Griffiths</b> Last <b>Griffiths</b>			4. DATE OF DEATH Month <b>8</b> Day <b>31</b> Year <b>1958</b>		
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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>5-18-97</b>	9. AGE (In years Last birthday) <b>61</b>	10. FUNDER 1 YEAR Months <b>6</b> Days <b>1</b>	IF UNDER 24 HRS. Hours <b>1</b> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MANAGER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>CAFETERIA</b>	11. BIRTHPLACE (City and state or country) <b>BASEHOR, KANSAS</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>John Kobson</b>	13b. MOTHER'S MAIDEN NAME <b>Lottie Caruthers</b>	14. NAME OF HUSBAND OR WIFE <b>SAMUEL D. GRIFFITHS</b>
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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>487-07-5768</b>	17. INFORMANT <b>RAYMOND EGGENBERGER, 2115 W. 73RD. ST.</b> Address
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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>Lobar pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>35 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Secondary to chronic lymphatic leukemia</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>1</b>

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.)
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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 COUNTY _____ STATE _____
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21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at <b>9:27</b> P m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>R. S. Burns, M.D.</b>	22b. ADDRESS <b>24th &amp; Cherry</b>	22c. DATE SIGNED <b>9-2-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>SEPT. 2, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. HOPE CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY KANSAS</b>
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24. FUNERAL DIRECTOR <b>D.W. NEWCOMER'S SONS, MISSION, KANSAS</b>	25. DATE RECD. BY LOCAL REG. <b>9-2-58</b>	26. REGISTRAR'S SIGNATURE <b>Reva Minshall</b>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

B. I. Burns

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

*Albert L. Savage*

Licensed Embalmer No. *4812*

P. O. Address *Wenona, Ill.*

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.