Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-044133
STATE FILE NUMBER 5852

FILED DEC 30 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City — Inside Limits Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION General Hospital — Length of stay in Ib 60 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN 538 Kansas City — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 3607 Paseo — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First GRANT Middle Last Griggs

4. DATE OF DEATH Month 12 Day 10 Year 58

5. SEX Male

6. COLOR OR RACE Wh

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH 7-28-1866

9. AGE (In years last birthday) 92 — 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) Ret Bldg Contractor

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) Bates County Mo

12. CITIZEN OF WHAT COUNTRY? U S A

13a. FATHER'S NAME Seth Griggs

13b. MOTHER'S MAIDEN NAME Massie Ann Warner

14. NAME OF HUSBAND OR WIFE Lilly B. Griggs

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W W I

16. SOCIAL SECURITY NO. None

17. INFORMANT Mrs Margaret Miller Address 3607 Paseo K C Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia — 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) 491 h

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 12-2-58, to 12-10-58 and last saw her/him alive on 12-10-58
Death occurred at 10:50 AM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Abraham Gelperin (Degree or title) MD

22b. ADDRESS 24th + Cherry

22c. DATE SIGNED 12-10-58

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 12-12-58

23c. NAME OF CEMETERY OR CREMATORY Elmwood Cem.

23d. LOCATION (City, town, or county) Kansas City (State) Mo

24. FUNERAL DIRECTOR Wagner Funeral Home K C Mo — ADDRESS

25. DATE RECD. BY LOCAL REG. 12-11-58

26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Abraham Gelperin M.D.

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 Thomas A. Kachler

Licensed Embalmer No. 4993

P. O. Address K-C, Mo.

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.