

FILED DEC 23 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-045300

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 449

1. PLACE OF DEATH a. COUNTY <u>ST. FRANCOIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. FRANCOIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bonne Terre</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Bonne Terre</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in lb	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Maude</u> Middle <u>E</u> Last <u>GRIFFIN</u>			4. DATE OF DEATH Month <u>Dec</u> Day <u>6</u> Year <u>1958</u>		
5. SEX <u>FEMALE</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>NOV. 24, 1882</u>	9. AGE (In years last birthday) <u>76</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>0</u> 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>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Leeburg, MO.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13a. FATHER'S NAME <u>Ike Leah</u>		13b. MOTHER'S MAIDEN NAME <u>Alice Hill</u>		14. NAME OF HUSBAND OR WIFE <u>JAMES 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>James Griffin</u> Address <u>Bonne Terre, Mo</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>Cerebral hemorrhage</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost.	DUE TO (b) <u>Hypertension (arteriosclerotic)</u> <u>6-8 yrs</u>		
	DUE TO (c) <u>Nephritis (arteriosclerotic)</u> <u>2 to 3 yrs</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I: (a) <u>446 X</u>			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.)		
20c. TIME OF INJURY Hour <u>7:00</u> Month, Day, Year <u>1958</u> a.m. <u>P</u> 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 <u>Flat River, MO</u>	
21. I attended the deceased from <u>1953</u> to <u>Dec 6, 1958</u> and last saw her alive on <u>Dec 5, 1958</u> Death occurred at <u>7:00</u> <u>P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>F.W. Zupan DO.</u>			22b. ADDRESS <u>Flat River, MO</u>		22c. DATE SIGNED <u>12/8/58</u>

23a. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>Dec 9, 1958</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BETHANIA</u>	
24. FUNERAL DIRECTOR <u>Raymond Caldwell</u>		ADDRESS <u>Flat River, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Dec. 13, 1958</u>	
				26. REGISTRAR'S SIGNATURE <u>Ether Rudloff</u>	

(Licensed Embalmer's Statement on Reverse Side)

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 listed. 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 *R. Caldwell*

Licensed Embalmer No. *2531*

P. O. Address *Flat River, 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.