

Health, Welfare
Public
Service

8

THE DIVISION OF HEALTH OF MISSOURI
DEATH CERTIFICATE

59-013694

STATE FILE NUMBER

FILED MAY 6 1959 Registration District No. 146 Primary Registration District No. 5589 Registrar's No. 199

1. PLACE OF DEATH a. COUNTY <u>Jackson (Brookings)</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Kansas City, Mo.</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>9910 E 56th.</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>9910 E 56 -</u>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle Last <u>GRIFFITH</u>			4. DATE OF DEATH Month <u>4</u> Day <u>30</u> Year <u>59</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>9-24-1903</u>	9. AGE (In years) <u>55</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during last of working life, if retired) <u>MINISTER</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>EASTON-KANSAS</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13a. FATHER'S NAME <u>WILLIAM T. GRIFFITH</u>	13b. MOTHER'S MAIDEN NAME <u>LILLIE WILSON</u>	14. NAME OF HUSBAND OR WIFE <u>LOIS GRIFFITH</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or <u>NO</u>) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>MRS. LOIS GRIFFITH - 9910 E 56 - 15 P.M.</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>Cardiac Decompensation</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Malnutrition</u>	
	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"/> <u>2</u>

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>none</u>	
20c. TIME OF INJURY Hour _____ 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.) <u>none</u>	20f. CITY, TOWN, OR LOCATION	COUNTY STATE

21. I attended the deceased from <u>Apr. 30/59</u> to <u>Apr. 30/59</u> and last saw him <u>alive on D.O.A.</u> Death occurred at <u>11 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.		
--	--	--

22a. SIGNATURE (Degree or title) <u>Edw. H. Bird D.O.</u>	22b. ADDRESS <u>2 0444 E. 67 Terr.</u>	22c. DATE SIGNED <u>5-1-59</u>
--	---	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL <u>REMOVAL</u>	23b. DATE <u>5-2-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hiland Bur.</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City, Kas.</u>
---	----------------------------	--	---

24. FUNERAL DIRECTOR <u>SKRADSKI - STINE - K. P. Co.</u>	ADDRESS <u>K. P. Co.</u>	25. DATE RECD. BY LOCAL REG. <u>5-2-59</u>	26. REGISTRAR'S SIGNATURE <u>James S. Craig</u>
---	-----------------------------	---	--

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MAY 29 1959

JAN 15 1960

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 *J. L. Roy Mooney*

Licensed Embalmer No. *4776*

P. O. Address *K.C. Mooney*

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.