

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED JUL 7 1959

59-023769

Registration District No. 319 Primary Registration District No. 4469 Registrar's No. 40

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>STE. Genevieve</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>STE. Genevieve</u>							
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>STE. Genevieve</u>		Length of stay in 1b <u>2 MONTHS</u>		c. CITY OR TOWN <u>MINNITH</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>STE. Genevieve Rest Home</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>RIVER Aux VASES, Mo.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles B GRIFFARD</u>				4. DATE OF DEATH Month Day Year <u>JUNE 30 1959</u>							
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>12/3/1878</u>		9. AGE (last birthday) <u>80</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>FARMER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (City and state or country) <u>MINNITH, MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>				
13a. FATHER'S NAME <u>Felix GRIFFARD</u>				13b. MOTHER'S MAIDEN NAME <u>SARAH Lewis</u>				14. NAME OF HUSBAND OR WIFE <u>ALMA Woodruff</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 Address <u>James Griffard - Minnith 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>Chronic Myocarditis</u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>			
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)								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 a.m. p.m.		Month, Day, Year									
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			
21. I attended the deceased from <u>June 8 1959</u> to <u>June 30 1959</u> and last saw her alive on <u>June 30 1959</u> Death occurred at <u>June 30 1959</u> m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) <u>Arthur St. Louis MD</u>						22b. ADDRESS <u>St. Genevieve Mo</u>				22c. DATE SIGNED <u>7-2-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>7/3/59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CREST LAWN CEMETERY STE. Genevieve Mo</u>				23d. LOCATION (City, town, or county) (State) <u>STE. Genevieve Mo</u>			
24. FUNERAL DIRECTOR <u>BASLER FUNERAL HOME STE. Genevieve, Mo</u>				ADDRESS		25. DATE RECD. BY LOCAL REG. <u>July 2, 1959</u>		26. REGISTRAR'S SIGNATURE <u>Walter O. Basler</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Adrian J. Eklun

Licensed Embalmer No. 4740

P. O. Address Ste. Geneva

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.