

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023818

STATE FILE NUMBER

FILED JUL 3 1959

Registration District No. 333

Primary Registration District No. 3074

Registrar's No. 113

300
-57

1. PLACE OF DEATH a. COUNTY SCOTT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY SCOTT	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SIKESTON		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN SIKESTON
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 332 ALABAMA		Length of stay in 1b 7 YRS	d. STREET ADDRESS 332 ALABAMA (If outside, give location)
3. NAME OF DECEASED (Type or print) First ED Middle — Last GRIFFIN		4. DATE OF DEATH Month 6 - Day 15 - Year 39	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-17-1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (City and state or country) CHARLESTON, MISS.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME —	
13b. MOTHER'S MAIDEN NAME —		14. NAME OF HUSBAND OR WIFE —	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. —	17. INFORMANT Address MARY IDAGIVINS, SIKESTON, MO.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis			INTERVAL BETWEEN ONSET AND DEATH ± 5 Min.
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) 4201			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 _____ Month, Day, Year _____ 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.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from First Call after death and last saw her alive on Death occurred between 6 + 7 P. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Thelma C. Beckthorn, M.D. Health Officer 5		22b. ADDRESS Benton, Mo	22c. DATE SIGNED 6-23-59
23a. BURIAL, CREMATION, REMOVAL (Specify) 29-0	23b. DATE 6-19-59	23c. NAME OF CEMETERY OR CREMATORY SUNSET	23d. LOCATION (City, town, or county) (Street) SIKESTON, MO.
24. FUNERAL DIRECTOR ADDRESS ALVIN DOTSON, SIKESTON, MO		25. DATE RECD. BY LOCAL REG. 6-24-59	26. REGISTRAR'S SIGNATURE Thelma C. Beckthorn

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Chris S. Marshall*

Licensed Embalmer No. *4601*

P. O. Address *Leicester - W*

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.