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FILED VS SEP 11 1959

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-030438
STATE FILE NUMBER

Registration District No. ..... Primary Registration District No. ..... Registrar's No. 27940

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN — Inside Limits Yes ☐ No ☐	c. CITY OR TOWN St. Louis, Mo — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hosp — Length of stay in 1b 4 Months	d. STREET ADDRESS (If outside, give location) 1919 S. Grand Blvd., — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: Bertha	Middle: I.	Last: Griffin	4. DATE OF DEATH Month Day Year: 8-26-59
5. SEX: female	6. COLOR OR RACE: white	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: 8-5-1873
9. AGE (In years last birthday): 86	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): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: Kept House	11. BIRTHPLACE (City and state or country): St. Louis, Mo	12. CITIZEN OF WHAT COUNTRY?: U.S.
13a. FATHER'S NAME: Charles Weber	13b. MOTHER'S MAIDEN NAME: Anna Herkert	14. NAME OF HUSBAND OR WIFE: Joseph M. Griffin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: No	17. INFORMANT: Mr. Robert W. Hammerstein	Address: 1701 -V. Bldg Mississippi

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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) Melanocarcinoma of rectum — INTERVAL BETWEEN ONSET AND DEATH: 3 years

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c) 154X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): General senility

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 April 21, 1959 to Aug 26 and last saw her alive on Aug 26, 1959

Death occurred at 1:30 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Birkle Eck M.D. (Degree or title) 22b. ADDRESS 950 Francis Pl 22c. DATE SIGNED Aug 27

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 8-29-59	23c. NAME OF CEMETERY OR CREMATORY: Oak Grove Mausoleum	23d. LOCATION (City, town, or county) (State): St. Louis County
24. FUNERAL DIRECTOR: Weick Bros	ADDRESS: 2201 S. Grand Blvd.	25. DATE REC'D BY LOCAL REG.: AUG 27 '59	26. REGISTRAR'S SIGNATURE: Noal Smith M.D.

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 emb

by me, or by ....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed Harvey Kable

Licensed Embalmer No. 4596

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fa
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.