

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035345

FILED VS NOV 16 1959 *43*

Registration District No. _____ Primary Registration District No. *3007* Registrar's No. *514*

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY Butler		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Stoddard	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Poplar Bluff	Length of stay in 1b 3 hours	c. CITY OR TOWN Bernie, Mo.	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Poplar Bluff hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1 mile north of Bernie
		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Dee Middle Ves Last Griffin			4. DATE OF DEATH Month Oct. Day 24, Year 1959		
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5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH May 12, 1893	9. AGE (last birthday) 66	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Agriculture	11. BIRTHPLACE (City and state or country) Carmi, Illinois	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Jacob Ellsworth Griffin	13b. MOTHER'S MAIDEN NAME Vestie Sutton	14. NAME OF HUSBAND OR WIFE Florence Corene Griffin
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes World War # 1	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Address Mrs. Florence Griffin Bernie, Mo. Rt. 1
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of Skull and Structural injury		INTERVAL BETWEEN ONSET AND DEATH 10-24-59 3 hours
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
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) Automobile
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway	20f. CITY, TOWN, OR LOCATION Wagon Bernie, Mo Stoddard, Mo	COUNTY _____ STATE _____
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21: I attended the deceased from **10-24 9:10 P.** and last saw her him alive on **10-24-59**
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) S.S. Davis M.D.	22b. ADDRESS Poplar Bluff, Mo	22c. DATE SIGNED 11-2-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-27-59	23c. NAME OF CEMETERY OR CREMATORY Bernie Cemetery	23d. LOCATION (City, town, or county) Bernie, Mo.	(State) _____
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24. FUNERAL DIRECTOR ADDRESS Duffie-Kainey funeral home Bernie, Mo.	25. DATE RECD. BY LOCAL REG. 11/3/59	26. REGISTRAR'S SIGNATURE R. M. Minter
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 16 1959 SA

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 Raymond L. Ruffie

Licensed Embalmer No. 4798

P. O. Address Berrie, 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.