

FILED VS. DEC. 2 1960

1. PLACE OF DEATH a. COUNTY 9 mo.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 20 days	c. CITY OR TOWN St. Louis	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hosp.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1235 N. 11th St.	
3. NAME OF DECEASED (Type or print) First Tom Middle Last Griffin		4. DATE OF DEATH Month 11 Day 10 Year 60		
5. SEX male	6. COLOR OR RACE col.	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-12-80	9. AGE (last birthday) 80
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (City and state or country) Ark.
13a. FATHER'S NAME George Griffin		13b. MOTHER'S MAIDEN NAME Minerva Griffin		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) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Hospital Records 5800 Arsenal

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Pyelonephritis		INTERVAL BETWEEN ONSET AND DEATH 10 mo.
DUE TO (b) _____		
DUE TO (c) 6000		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Rt. Middle Cerebral Artery Thrombosis		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 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.)
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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 St. Louis, Mo.	COUNTY _____ STATE _____
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21. I attended the deceased from 1-21-60 to 11-10-60 and last saw her/him alive on 11-10-60	
Death occurred at 8:15 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE (Degree or title) John W. Beckham, M.D.	22b. ADDRESS 5800 Arsenal	22c. DATE SIGNED 11/11/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Rowland-Rite	23b. DATE 11-30-60	23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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24. FUNERAL DIRECTOR Rowland-Rite	ADDRESS 4104 Manchester	25. DATE RECD. BY LOCAL REG. NOV 25 1960	26. REGISTRAR'S SIGNATURE Loal Smith, M.D.
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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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.