

FEDERAL BUREAU OF INVESTIGATION - DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048155

FILED VS JAN 16 1961

317

Primary Registration District No. 541

Registrar's No. 3818

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY ST LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY JEFFERSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CLAYTON		Length of stay in 1b 3 HRS.	c. CITY OR TOWN FESTUS Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST LOUIS CO. HOSP.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 307 GRAND Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last WAYNE J. GRIFFITH			4. DATE OF DEATH Month Day Year 12-31-60			
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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 5-28-91	9. AGE (last birthday) 69	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED	10b. KIND OF BUSINESS OR INDUSTRY MO. NAT. GAS CO.	11. BIRTHPLACE (City and state or country) MAGAN, KY.	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME MACK HENRY GRIFFITH	13b. MOTHER'S MAIDEN NAME ELLA BAIZE	14. NAME OF HUSBAND OR WIFE NORA
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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) NO.	16. SOCIAL SECURITY NO. _____	17. INFORMANT Address EVERETT GRIFFITH PEVELY, MO.
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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) Traumatic Rupture of Thoracic Aorta		INTERVAL BETWEEN ONSET AND DEATH 3 hrs
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) Multiple lacerations of liver	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 checked="" type="checkbox"/> NO <input 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.) Auto accident
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20c. TIME OF INJURY Hour a.m. p.m. 2:00 p.m.	Month, Day, Year 12 31 60
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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.) 100 Lemay Ferry Rd.	20f. CITY, TOWN, OR LOCATION St. Louis	COUNTY Mo.	STATE
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21. I attended the deceased from **12-31-60** to **12-31-60** and last saw her/him alive on **12-31-60**
Death occurred at **4:50** ~~am~~ **p.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Paul W. Schaper M.D.	22b. ADDRESS 6015 Brentwood, Clayton, Mo.	22c. DATE SIGNED 1/4/61
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23a. BURIAL, CREMATION, OR REMOVAL (Specify) REMOVAL	23b. DATE 1-5-61	23c. NAME OF CEMETERY OR CREMATORY ROSELAWN GARDEN CEM.	23d. LOCATION (City, town, or county) (State) CRYSTAL CITY, MO.
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24. FUNERAL DIRECTOR Gentry R. Polittle	ADDRESS Crystal City, Mo.	25. DATE RECD. BY LOCAL REG. 1-4-61	26. REGISTRAR'S SIGNATURE John C. Murphy
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1961 8 1 NOV 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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Dentry P. Salter*

Licensed Embalmer No. 348

P. O. Address Crystal

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