

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 30 1961

61-004087

STATE FILE NUMBER

AMENDED ✓

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 145

1. PLACE OF DEATH a. COUNTY Mo				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY ST LOUIS				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Normandy		Length of stay in 1b YRS		c. CITY OR TOWN Normandy		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 6815 Duckworth			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 6815 Duckworth		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Peter Middle M Last Griffin			4. DATE OF DEATH Month 1 Day 15 Year 61					
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 8-29-96	9. AGE (last birthday) 64	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Mg		10b. KIND OF BUSINESS OR INDUSTRY D.A.V.		11. BIRTHPLACE (City and state or country) St Louis Mo		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME Michael J. Griffin			13b. MOTHER'S MAIDEN NAME Mary Anglin		14. NAME OF HUSBAND OR WIFE Leona			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war, or dates of service) War I				17. INFORMANT Address Mrs Leona E. Griffin 6815 Duckworth				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction						INTERVAL BETWEEN ONSET AND DEATH 10min		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.)						DUE TO (b) Coronary Artery Disease 1yr.		
						DUE TO (c) Arteriosclerotic Heart Dis. 2yrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes mellitus						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		
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 _____ 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		COUNTY	STATE
21. I attended the deceased from Nov 1960 to 11/15/61 and last saw him alive on 11/4/61 Death occurred at 7:30 P m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) Murray Chucky M.D.				22b. ADDRESS 6223 Natural Bridge		22c. DATE SIGNED 1/16/61		
23a. BURIAL, CREMATION, OR REMOVAL (Specify)	23b. DATE 1-18-1961	23c. NAME OF CEMETERY OR CREMATORY Calvary		23d. LOCATION (City, town, or county) St Louis Mo		23e. STATE		
24. FUNERAL DIRECTOR Walter J. Donnelly			ADDRESS 3840 Lindell Blvd		25. DATE RECD. BY LOCAL REG. 1-16-61	26. REGISTRAR'S SIGNATURE Josiah E. Murphy M.D.		

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

JAN 31 1961

FEB 3 1961

1-4.PM

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 *W. S. Taylor*

Licensed Embalmer No. 4697

P. O. Address 3810 Lindale

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.