

SSOUR DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED MAY 4 1961 AMENDED District No. 318 Primary Registration District No. 1003 Registrar's No. 4010-61-015179 STATE FILE NUMBER

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
SHOULD READ
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis											
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Length of stay in lb 5 weeks		c. CITY OR TOWN Brentwood		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>									
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 9112 Eager Rd.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First CHARLES Middle W. Last GRIFFIN				4. DATE OF DEATH Month APRIL Day 24 Year 1961											
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 7-3-1884		9. AGE (last birthday) 76		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) Minister				10b. KIND OF BUSINESS OR INDUSTRY Methodist Ch.		11. BIRTHPLACE (City and state or country) Saratoga, Ark.		12. CITIZEN OF WHAT COUNTRY USA							
13a. FATHER'S NAME Rufus Griffin				13b. MOTHER'S MAIDEN NAME Maretta Jane Reeves				14. NAME OF HUSBAND OR WIFE Virginia Griffin							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None						7. INFORMANT Valley Park, Missouri Frances Reiff-274, Big Bend Rd.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CEREBRAL VASCULAR DISEASE WITH BASILAR ARTERY INSUFFICIENCY										INTERVAL BETWEEN ONSET AND DEATH 2 YEARS					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 334X															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) GENERALIZED ARTERIOSCLEROSIS, SEVERE. ARTERIOSCLEROTIC HEART DISEASE. ARTERIOLAR NEPHROSCLEROSIS WITH RENAL FAILURE								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 checked="" type="checkbox"/> NO <input 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 Month, Day, Year a.m. p.m.				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 JAN. 23, 1941 to APRIL 24, 1961 and last saw her him alive on APRIL 24, 1961 Death occurred at 6:55 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE C. D. McMillian, M.D.						22b. ADDRESS BARNES HOSPITAL				22c. DATE SIGNED 4/25/61					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 4-27-1961		23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cem.				23d. LOCATION (City, town, or county) Kirkwood 22, Mo.							
24. FUNERAL DIRECTOR Pfitzinger Mort-Kirkwood 22, Mo.				ADDRESS		25. DATE RECD. BY LOCAL REG. APR 27 1961		26. REGISTRAR'S SIGNATURE Karl Smith, M.D.							

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 Herbert J. Lane Jr

Licensed Embalmer No. 4800

P. O. Address Kirkwood, 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.