# SSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5737 STATE FILE NUMBER -61-022621

FILED JUN 29 1961

1. PLACE OF DEATH
a. COUNTY: St Louis Mo.
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St Louis Mo. — Length of stay in 1b: 1 yr 10 mos.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 5037 Enright ~~& Kingshighway~~ — Inside Limits Yes ☐ No ☐ x

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri — b. COUNTY: St Louis
c. CITY OR TOWN: St Louis Missouri — Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location): 5587 Cabanne Avenue — Reside on Farm Yes ☑ No ☐

3. NAME OF DECEASED (Type or print): First Middle Last — AKA: ROSE-MARY GRIFFIN — Rosa Lee Griffin
4. DATE OF DEATH: Month Day Year — June 13 1961
5. SEX: Female
6. COLOR OR RACE: Negro
7. Married ☐ Widowed ☐ Never Married ☒ Divorced ☐
8. DATE OF BIRTH: 8/16/59
9. AGE (last birthday): 1 Yr — IF UNDER 1 YEAR: Months 10 Days — IF UNDER 24 HR: Hours Min.
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): St Louis Missouri
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: James Griffin
13b. MOTHER'S MAIDEN NAME: Annie Mae Shell
14. NAME OF HUSBAND OR WIFE: None
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: James Griffin — Address: 5587 Cabanne

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY: — INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a): Nutritional Deficiency (Starvation)
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b):
DUE TO (c): 286.7
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 _____ to _____ and last saw her/him alive on _____
Death occurred at 10:46 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Joseph M. Quinn Deputy Coron
22b. ADDRESS: 1300 Clark
22c. DATE SIGNED: 6-20-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 6/22/61
23c. NAME OF CEMETERY OR CREMATORY: Father Dicksons
23d. LOCATION (City, town, or county) (State): Crestwood Mo

24. FUNERAL DIRECTOR: T. Yandell & Sons — ADDRESS: 1776 E. Kickham
25. DATE RECD. BY LOCAL REG.: JUN 20 1961
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

DATE AMENDED — INSTEAD OF — SHOULD READ — ITEM NO. — DOCUMENT — BY AFFIDAVIT OF — MEDICAL CERTIFICATION

**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 Theodore P. Yandell

Licensed Embalmer No. 4243

P. O. Address 130 Eldridge
Webster Groves

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