FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED SEP 23 1948
Registration District No. 1986

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6074

State File No. 30787

Registrar's No. 305

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County St. Francois
(b) City or town Desloge
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 209 South Grant
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 50 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County St. Francois
(c) City or town Desloge, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 209 S. Grant
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME James Walter Grifford
3. (b) If veteran, name war .....
3. (c) Social Security No. 488-16-5485

4. Sex Male
5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Sarah E. Nance Grifford
6. (c) Age of husband or wife if alive 62 years
7. Birth date of deceased November (Month) 11 (Day) 1879 (Year)

8. AGE: Years 68 | Months 10 | Days 5 | If less than one day ..... hr. ..... min.

9. Birthplace Ste Genevieve (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Master Mechanic
11. Industry or business Lead Industry
FATHER
12. Name James B. Grifford
13. Birthplace Unknown (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Mary E. Thomure
15. Birthplace Ste Genevieve Co. Mo. (City, town, or county) (State or foreign country)
16. (a) Informant Sarah E. Griffard
(b) Address Desloge, Mo.
17. (a) burial (Burial, cremation, or removal) (b) Date thereof 9-25-48 (Month) (Day) (Year)
(c) Place: burial or cremation St. Francois
18. (a) Signature of funeral director C. Z. Boyer & Son
(b) Address Desloge, Mo.
19. (a) 9-20-48 (Date received local registrar) (b) Esther Rudloff (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 16
year 1948 hour 11 minute 15 P.M.
21. I hereby certify that I attended the deceased from Sept 10, 1948, to Sept 16, 1948
that I last saw him alive on Sept 14, 1948;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Sanguineous Effusion	
Due to: arteriosclerosis	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	

PHYSICIAN
Underline the cause of which death should be charged statistically.

Major findings:
Of operations .....
Of autopsy .....

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) .....
(b) Date of occurrence .....
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury .....

23. Signature C. H. Copeland (M. D. or other) M.D.
Address Flat River, Mo. Date signed 9-17-48

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 4
District File Number 948-12
Date Filed 9-22-48

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_____ Registered Apprentice No._____, working under my personal supervision.

Signed L. T. Sayers

Licensed Embalmer No. 3660

P. O. Address Leasburg, 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 this body is not embalmed, fact should be so stated above.