LOCAL REGISTRAR'S RECORD — DO NOT TEAR LEAF

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

# MISSOURI STATE BOARD OF HEALTH
## BUREAU OF VITAL STATISTICS
### CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Cooper

Township Otterville or Village Otterville or City ..... (NO. ..... St. ..... Ward)

Registration District No. 221 File No. 31329-C

Primary Registration District No. 4134 Registered No. .....

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Claude D Garman

**PERSONAL AND STATISTICAL PARTICULARS**

3 SEX Male

4 COLOR OR RACE White

5 ~~SINGLE~~ MARRIED ~~WIDOWED~~ ~~OR DIVORCED~~ (Write the word) married

6 DATE OF BIRTH Feb (Month) 2 (Day), 1874 (Year)

7 AGE 46 yrs. 8 mos. 8 ds. If LESS than 1 day, ..... hrs. or ..... min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work retired farmer

(b) General nature of industry business, or establishment in which employed (or employer) good

9 BIRTHPLACE (City or town, State or foreign country) Indianapolis Ind

PARENTS

10 NAME OF FATHER John Garman

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Ireland

12 MAIDEN NAME OF MOTHER Dolly Ann Hamilton

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs C D Garman

(Address) Otterville Mo

15 Filed 10/10, 1920. Robert L Logle Registrar

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH Oct (Month) 10 (Day), 1920 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Sept 15, 1920, to Oct 10, 1920, that I last saw him alive on Oct 10, 1920 and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

Cancer of Mouth

45c

(Duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Robert L Logle M. D.

10/10, 1920 (Address) Otterville

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL Carrollton Mo

DATE OF BURIAL Oct 11 1920

20 UNDERTAKER J L Spillers

ADDRESS Otterville Mo

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

# MISSOURI STATE BOARD OF HEALTH
## BUREAU OF VITAL STATISTICS
### CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ..... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word) |
|---|---|---|
| | | |

6 DATE OF BIRTH

..... (Month) ....., 1..... (Year) (Day)

7 AGE ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ..... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., .....
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ....., 191..... (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....,
that I last saw h..... alive on ....., 191.....,
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....
.....
.....
..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

| 19 PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ....., 191..... |
|---|---|
| 20 UNDERTAKER | ADDRESS |