LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

C

7241

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

1. PLACE OF DEATH
County Christian — Registration District No. 184 — File No.
Township McCracken — Primary Registration District No. 6252 — Registered No. 7
City McCracken, Mo. (No. ... St. ... Ward)

2. FULL NAME John R. Garrison
(a) Residence. No. ... St., ... Ward. ... (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U.S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Iza Garrison

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Oct. 22 1878

7. AGE: Years 46 — Months 5 — Days 2 — If LESS than 1 day, ... hrs. or ... min.

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): missouri

PARENTS
10. NAME OF FATHER: John Garrison
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Tennessee
12. MAIDEN NAME OF MOTHER: Martha Roark
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Kentucky

14. INFORMANT: Lee Garrison
(Address) Ozark, Mo., R.R.

15. FILED May 8, 1925 Loretta M Leonard, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): March 24 1925

17. I HEREBY CERTIFY, That I attended deceased from Nov 10, 1924, to Mar 18, 1925, that I last saw him alive on Mar 18, 1925, and that death occurred, on the date stated above, at 1:30 O'clock a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Sarcoma upper third of left Femur

530 (duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (SECONDARY) 49 (duration) ... yrs. ... mos. ... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? yes. DATE OF Dec 4-1924
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Microscopic view of tissue
(Signed) R. R. Farthing, M. D
Mar 30, 1925 (Address) Ozark Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: McCracken Cemetery — DATE OF BURIAL: March 25 1925

20. UNDERTAKER: T. B. Chaffin — ADDRESS: Ozark, Mo.

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.

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CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....Ward)

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED.

(a) Trade, profession, or particular kind of work .....

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19.....
that I last saw h..... alive on....., 19....., 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.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

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

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

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