

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

C-15300

8 922

PLACE OF DEATH
County Livingston Registration District No. 512 File No. _____
Township mooreville Primary Registration District No. 5673 Registered No. 4
City _____ (No. _____) St. _____ (Ward _____)

2. FULL NAME John William Garlick

(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 58 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 3 - 1867

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
61 | 6 | 6 | | |

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) Franklin Co Va. (STATE OR COUNTRY)

10. NAME OF FATHER Chas P. Garlick

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

12. MAIDEN NAME OF MOTHER Mary Burnett

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

14. INFORMANT Thomas Garlick (Address) Mooreville, Mo.

15. FILED 4/10 1929 Anna O. Carpenter REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 9 1929

17. I HEREBY CERTIFY, That I attended deceased from Feb 20 1927 to Apr 9 1929 that I last saw him alive on Apr 8 1929, and that death occurred, on the date stated above, at 4:25 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Multiple abscesses of brain and Jordan (rt.)

(duration) yrs. mos. 50 da.

CONTRIBUTORY (SECONDARY) abscesses of Lungs.
(duration) yrs. mos. 35 da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? Yes DATE OF Feb 25 1929

WAS THERE AN AUTOPSY? No.

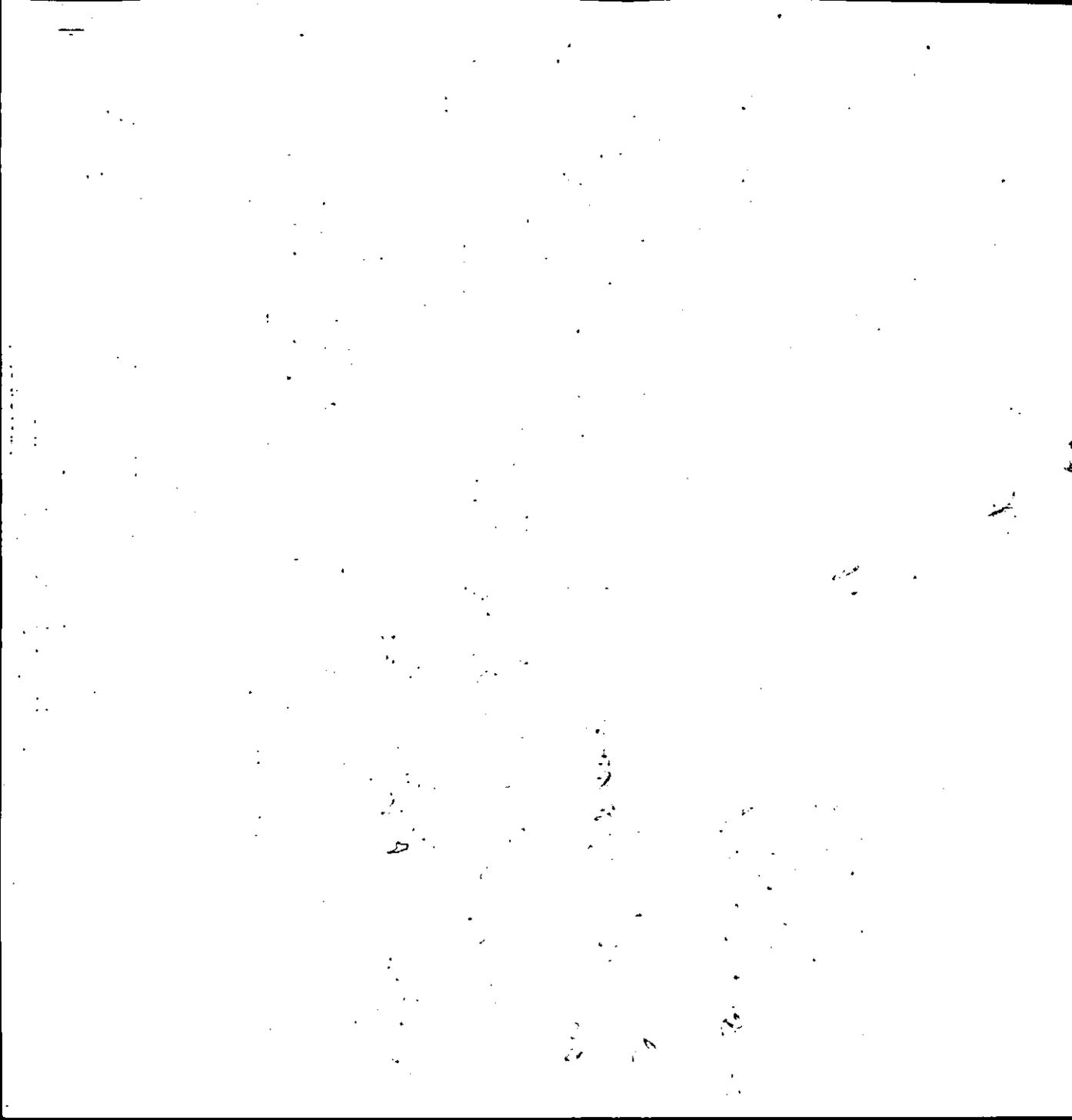
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) G W Carpenter, M. D.
4/10 1929 (Address) Utica Mo

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mooreville Cemetery DATE OF BURIAL Apr. 11 1929

20. UNDERTAKER T. Meeker Breckinridge ADDRESS _____

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Warren
Township Mooreville
City..... (No.....)..... St. Ward)

Registration District No. 212
Primary Registration District No. 5-679

File No.....
Registered No. 4

2. FULL NAME

John William Garlick

(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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)

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 6-8, 1929 Anna L. Carpenter REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 9 1929

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:

Multiple abscesses and gangrene of the lungs due to slight cut by knife against finger which occurred while...

CONTRIBUTORY (SECONDARY) Losses in lungs (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.

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

20. UNDERTAKER..... ADDRESS.....

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY L.V.

S-15300