

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

Do not use this space.

Dr. Jellison
4318
File No. _____
Registered No. 93
St. _____ Ward _____

1. PLACE OF BIRTH

39 County Greene Registration District No. 318
3 Township _____ Primary Registration District No. 2001
5 City Springfield, Mo. No. 1119 N. Blvd

2. FULL NAME Doc H. Garner

(a) Residence. No. 1119 N. Blvd 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 15, 1872

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
39 7 19

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Printer 40
(b) General nature of industry, business, or establishment in which employed (or employer) Wagon + Trailer Co.
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo. 2

10. NAME OF FATHER William Garner

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

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown 31

14. INFORMANT (Address) Lenny Garner Springfield, Mo.

15. FILED 24 1932 Don Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-2-1932

17. I HEREBY CERTIFY, That I attended deceased from Sept 1-20, 1930 to 2-2-1932, that I last saw him alive on 1-30-1932, and that death occurred, on the date stated above, at 7:30 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary T. B.
7 2 11
930
(duration) 3 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Mysocarditis
(duration) 2 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) C. E. Fuller, M. D.

2-3-1932 (Address) Springfield, 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 HOMICIDE.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
Rest Home 25 1932

20. UNDERTAKER
W. Penneyer Springfield, Mo.

K. 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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MAR 1932

