

DEC'D NOV 21 1938

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

34784

Do not use this space.

1. PLACE OF DEATH

(a) County Garrison Registration District No. 399
(b) Township Yean Primary Registration District No. 1002 Registered No. 4120
(c) City Kansas City (d) Street No. General Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

(a) Residence, No. 1331 Bellefontaine (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

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 Mrs. Fannie B. Garrison

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 19, 1856

7. AGE YEARS 82 MONTHS 7 DAYS 0 If LESS than 1 day,hr. ormin.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. none
9. Industry or business in which work was done, as saw mill, bank, etc. none
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation. 1

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Decatur, Iowa

13. NAME John Garrison

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ind.

15. MAIDEN NAME Missouri Simmons

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ind.

17. INFORMANT (ADDRESS) Reverend Clerk KC Gen Hosp KC Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Floral Hills DATE Oct 22, 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) John W. Wagner Kansas City, Mo.

20. FILED 10-22, 1938 M. M. Crowe Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-14, 1938

22. I HEREBY CERTIFY, That I attended deceased from 10-17, 1938, to 10-19, 1938
I last saw him alive on 10-19, 1938 Death is said to have occurred on the date stated above, at 11:15 AM
The principal cause of death and related causes of importance were as follows:

Cerebral sclerosis Date of onset
Encephalomalacia
8764

Other contributory causes of importance:

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy? yes

If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19.....

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) P. F. De Maria, M. D.

(Address) Supt KC Gen Hosp KC

STATEMENT BY LICENSED EMBALMER
RECORDING INSTITUTION

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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, above space should be left blank.