DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

NOV

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 35967

Registration District No. 266 Primary Registration District No. 5377 Registrar's No. 80

1. PLACE OF DEATH:

(a) County Dent

(b) City or town Rural Short Bend
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: XXXXXX
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution XXX (Specify whether
In this community all her life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dent

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. xxxxNear Salem Mo
(If rural, give location)

(e) If foreign born, how long in U. S. A.? XXXX years.

3. (a) PRINT FULL NAME Stella Francis Garrison

3. (b) If veteran, name war XXX

3. (c) Social Security No. XX

4. Sex female

5. Color or race White

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Samuel E Garrison

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased Nov 24 (Month) 1880 (Day) (Year)

8. AGE: Years 58 Months 10 Days 20 If less than one day hr. min.

9. Birthplace Dent Co (City, town, or county) Mo (State or foreign country)

10. Usual occupation housewife

11. Industry or business XXX

FATHER
12. Name John Groves
13. Birthplace ---- (City, town, or county) ---- (State or foreign country)

MOTHER
14. Maiden name Mary Edington
15. Birthplace --- (City, town, or county) --- (State or foreign country)

16. (a) Informant's own signature Samuel E. Garrison
(b) Address Howes Station, Mo

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 10/15/39 (Month) (Day) (Year)
(c) Place: burial or cremation Sligo Cem

18. (a) Signature of funeral director Carl K. Spencer
(b) Address Salem Mo

19. (a) October 15/39 (Date received local registrar) (b) F.F. Butler M.D. (Registrar's signature) M.E.B.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 14
year 1939 hour 10 minute 10 A.M.

21. I hereby certify that I attended the deceased from 9-1-39, 19__, to 10-12, 1939
that I last saw her alive on 10-12, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Chronic Rheumatic Valvular Heart Disease - Secondary Anemia	unknown
Due to	
Due to	
Other conditions none (Include pregnancy within 3 months of death)	
Major findings: Of operations none	
Of autopsy none	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury 3

23. Signature Jas. W. McNeal (M. D. or other) D.O.
Address Salem, Mo. Date signed 10-14-39

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

Rev. 5-17-39 I X19311

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.

RECEIVED
District Health Officer No. 5,
District File Number 139391
Date Filed 1 8 39

Signed Wm. W. McDonald

Licensed Embalmer No. 3806

P. O. Address Salem, Mo.

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.