

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

Do not use this space.

FILED MAR 21 '40

6287

1. PLACE OF DEATH
 County Christian Registration District No. 184
 Township Linker Primary Registration District No. 4110
 City Ozark Mo. (No.) St. Ward
 2. FULL NAME Winnie Garrison
 (a) Residence, No. 0 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 F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Widow
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 18 1891
 7. AGE YEARS 68 MONTHS 5 DAYS 14 If LESS than 1 day, hrs. or min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Home Keeper
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri
 MOTHER 13. NAME Stevan Butcher
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) England
 15. MAIDEN NAME Olivia Herald
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) W. Va.
 17. INFORMANT Ed Love
 (ADDRESS) Ozark Mo.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Ozark Mo. DATE March 3 1940
 19. UNDERTAKER T. B. Chaffin
 (ADDRESS) Ozark Mo.
 20. FILED March 10 1940 Levetta Leonard
 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 2 1940
 22. I HEREBY CERTIFY, That I attended deceased from Sept 28, 1939, to March 2, 1940
 I last saw him alive on March 1 1940, 1940. Death is said to have occurred on the date stated above, at 1 A. m.
 The principal cause of death and related causes of importance were as follows:
Cancer of Face and neck
 Date of onset
 Other contributory causes of importance:
 Name of operation Date of
 What test confirmed diagnosis? Was there an autopsy?
 23. 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? No
 If so, specify
 (Signed) J. H. Wade M. D.
 (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.

1 X704

RECEIVED

District Health Officer No. 6,

District File Number 340-891

Date Filed MAR 19 1940

57

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. **6287**

Registration District No. **184**

Primary Registration District No. **6287**

Registrar's No. **7**

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

1. PLACE OF DEATH:

(a) County **Christian**
(b) City or town **Ozark**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Minnie Garrison**

3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex **7** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **wid**
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years **68** Months **5** Days **14** If less than one day hr min

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

10. Usual occupation

11. Industry or business

MOTHER FATHER { 12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A. ? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **3** day **2** year hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him alive on and that death occurred on the date and hour stated above.

Immediate cause of death **Cancer of face and neck.**

Due to **Started on forehead.**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Duration
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?

While at work? (Specify type of place) (e) Means of injury

23. Signature **J. H. Wade** (M. D. or other)
Address **Ozark Mo** Date signed

SUPPLEMENTARY

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. **6287**
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Registration District No. **184**

Primary Registration District No. **4110**

Registrar's No. **7**

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

1. PLACE OF DEATH:

(a) County **Christian**
(b) City or town **Osark**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.
In this community (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Christian**
(c) City or town **Osark**
(If outside city or town limits write "RURAL")
(d) Street No.
(If rural, give location)
(e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME

Minnie Garrison

3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex **7** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **wid**
6. (b) Name of husband or wife. 6. (c) Age of husband, or wife, if alive. years

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years **68** Months **5** Days **14** If less than one year, hr. min.

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

10. Usual occupation.

11. Industry or business.

12. Name.

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name.

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant.

(b) Address.

17. (a) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation.

18. (a) Signature of funeral director.

(b) Address.

19. (a) **March 10 1948** (b) **Luetta Leonard** (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Mar** day **2** year **1948** hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him alive on 19 and that death occurred on the date and hour stated above. Immediate cause of death.

Due to. Due to. Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations. Of autopsy.

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? While at work? (Specify type of place) Means of injury.

23. Signature **J. H. Wade** (M. D. or other) Address **Osark Mo** Date signed

SUPPLEMENTAL

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