

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

30038
Do not use this space.

1. PLACE OF DEATH

(a) County Worth Registration District No. 903
(b) Township North Primary Registration District No. 45-45
(c) City Grant City (d) Street No. _____ 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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. _____ St. ☐ (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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF J. P. Garver
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 15, 1861
7. AGE YEARS 78 MONTHS 8 DAYS 26 If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
9. Industry or business in which work was done, as saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) 1-3-36 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marshall Co. Iowa

13. NAME Simon Davidson

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

15. MAIDEN NAME Larah Beck

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

17. INFORMANT (ADDRESS) Mrs. Ed Bates Grant City, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Grant City, Mo. DATE 8/13, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. C. Trumble Grant City, Mo.

20. FILED Aug 14, 1940 Clifford Nass Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 11, 1940

22. I HEREBY CERTIFY, That I attended deceased from 1936 to Aug 11, 1940

I last saw him alive on Aug 11, 1940 Death is said to have occurred on the date stated above, at 6-20 p.m.

The principal cause of death and related causes of importance were as follows:

Cancer of Rectum with vast excitation

Other contributory causes of importance: Age

Name of operation Colostomy Date of Jan 38

What test confirmed diagnosis? Micro Was there an autopsy? No

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) Ired O. M. D.

(Address) Grant City, Mo.

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.....

Arch C. Dunfee

Licensed Embalmer No. *3252*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **30038**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **903**

Primary Registration District No. **45-45**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **North city**
(b) City or town **North city**
(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 _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT
FULL NAME

Della D. Garner

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 **W**

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if
alive _____ year

7. Birth date of deceased _____

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

78

8

36

h. 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) _____

(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) **Oct. 22, 1940** (b) _____

(Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **North**

(c) City or town **Grant City**
(If outside city or town limits write "RURAL")

(d) Street No. _____
(If rural, give location)

(c) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **Aug** day **11**
year **1940** 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 _____

Duration

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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 **Fred Muller** (M. D. or other) _____

Address **Grant City** Date signed **40**

SUPPLEMENTARY

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

