DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31283

FILED OCT 14 1940

Registration District No. ____ Primary Registration District No. 4018 Registrar's No. ____

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

1. PLACE OF DEATH: (a) County: Audrain
(b) City or town: Laddonia (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: mos 2 (Specify whether years, months or days)
In this community: life

2. USUAL RESIDENCE OF DECEASED: (a) State: Missouri (b) County: Audrain
(c) City or town: Laddonia (If outside city or town limits, write "RURAL")
(d) Street No.: 0 (If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: CLAYTON WADE GARNETT
3. (b) If veteran, name war: —
3. (c) Social Security No.: none
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Single
6. (b) Name of husband or wife: ____
6. (c) Age of husband or wife if alive: ____ years
7. Birth date of deceased: Feb (Month) 6 (Day) 1936 (Year)

8. AGE: Years 4 Months 8 Days 2 If less than one day ____ hr. ____ min.

9. Birthplace: Audrain Co (City, town, or county) Mo 0 (State or foreign country)
10. Usual occupation: 0
11. Industry or business: 0
12. Name (FATHER): Walter B Garnett
13. Birthplace (FATHER): Ralls Co. (City, town, or county) Mo. (State or foreign country)
14. Maiden name (MOTHER): Katherin Bershears
15. Birthplace (MOTHER): Ralls Co (City, town, or county) Mo (State or foreign country)
16. (a) Informant: W. B. Garnett
(b) Address: Laddonia Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct 9-1940 (Month) (Day) (Year)
(c) Place: burial or cremation: Salem Church
18. (a) Signature of funeral director: Harry G Grainger
(b) Address: Laddonia, Mo.
19. (a) 10-9-1940 (Date received local registrar) (b) W K McCall (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 8th. year 1940 hour 9 minute 10 P.M.
21. I hereby certify that I attended the deceased from Oct 6, 1940, to Oct. 8, 1940, that I last saw him alive on Oct 8, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Bronchopneumonia	2 day
Due to	
Due to	
Other conditions: Mongolian Idocy (Include pregnancy within 3 months of death)	

Major findings:
Of operations: ____
Of autopsy: ____

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: W B Paine (M. D. or other) D.O.
Address: Laddonia, Mo Date signed: 10-9-40

(Licensed Embalmer's Statement on Reverse Side)

1972

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 H. G. Granger, Registered Apprentice No. ..... working under my personal supervision.

Signed H. G. Granger

Licensed Embalmer No. 1297

P. O. Address Caddonia, Me

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, fact should be so stated above.

V. S. No. 2B
DM—2-21-40
I X22659

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MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31283

Registration District No. 24

Primary Registration District No. 4018

Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Andrain

(b) City or town Laddonia
(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 (Specify whether
In this community years, months or days)

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.

3. (a) PRINT FULL NAME Clayton Wade Garnett

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex m

5. Color or race W

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

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 4 Months 8 Days 2 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

MOTHER
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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 8
year 1940 hour minute M.

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

Immediate cause of death Broncho Pneumonia

Due to Malnutrition (No Preliminary Diseases)

Due to

Other conditions mongolian Idiocy
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy 1070

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

23. Signature R B Baize (~~M. D. or other~~) DO
Address Laddonia Mo Date signed 11-18-40