

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.

FILED OCT 23 1940

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

Do not use this space.

33429

1. PLACE OF DEATH
County North Registration District No. 904
Township Union Primary Registration District No. 6213-
City (No.) St. Ward

2. FULL NAME Siberia Oleva Smith Garrard
(a) Residence, No. St. Ward. (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 Female 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 Walter Garrard

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 24. 1862

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>77</u>	<u>10</u>	<u>3.</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

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) Northampton 1
Indiana

MOTHER FATHER

13. NAME James Smith 1

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana 1

15. MAIDEN NAME Julia Godfree

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New Jersey

17. INFORMANT (ADDRESS) Walter Garrard
Sheldon Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Brethren Comy DATE Aug. 31- 1940

19. UNDERTAKER (ADDRESS) Long & Boyd 591
Sheldon Mo.

20. FILED Aug. 31 1940 Mrs. O. H. Bond
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) August 27. 1940

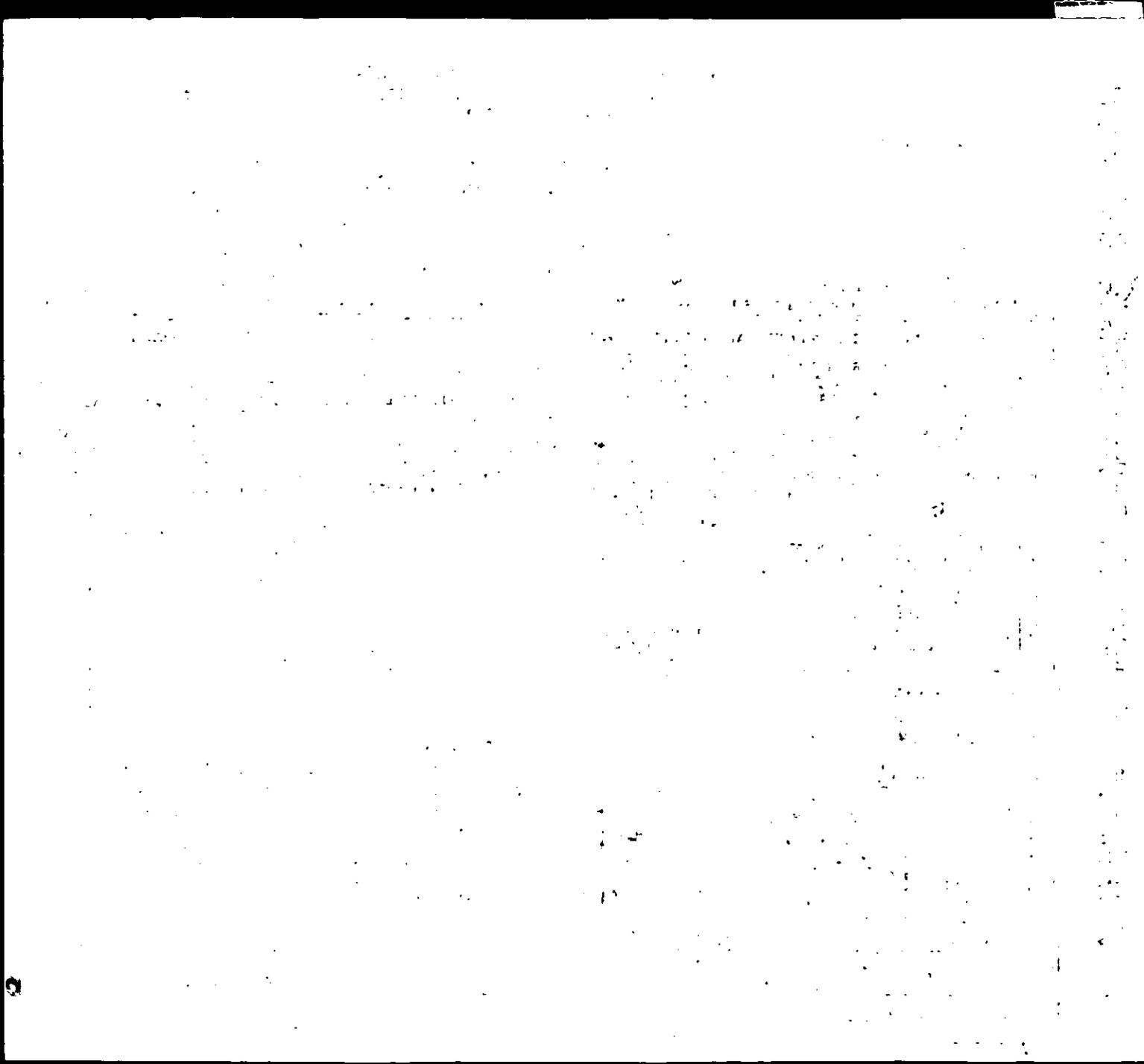
22. I HEREBY CERTIFY, That I attended deceased from August 1 1940, to August 27 1940
I last saw him/her alive on August 26 1940 Death is said to have occurred on the date stated above, at 7:00 a.m.
The principal cause of death and related causes of importance were as follows:
Angina pectoris
myocarditis
Date of onset 44

Other contributory causes of importance:

Name of operation Date of
What test confirmed diagnosis? 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?
If so, specify (Signed) R. G. Garten M.D.
(Address) Sheldon Mo



MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **32429**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **904**

Primary Registration District No. **6215-**

Registrar's No.

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

1. PLACE OF DEATH:

(a) County **Worth**

(b) City or town **Union TWP**
(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 **Missouri** (b) County **Worth**

(c) City or town **Sheridan Rural**
(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 **Siberia Oleva Smith Gaur**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

19. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **27**
year **1940** hour _____ minute _____ M.

4. Sex **F**

5. Color or race **W**

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

6. (b) Name of husband or wife _____

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

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

Immediate cause of death _____

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

8. AGE: Years **77** Months **10** Days **3**
If less than one day _____ min.

Due to _____

Due to _____

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

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **Aug 31, 1940** (b) **Mr. O. H. Bond**
(Date received local registrar) (Registrar's signature)

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) (Means of injury)

23. Signature **R. G. Garter** M. D. **a**
Address **Sheridan** **W. Va.** signed _____

SUPPLEMENTAL

