DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 33784

Registration District No. 7911 — Primary Registration District No. 1003 — Registrar's No. 8481

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. PLACE OF DEATH:

(a) County St Louis, Mo

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

(c) Name of hospital or institution: BARNES HOSPITAL

(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 OKLAHOMA (b) County

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

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

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

3. (a) PRINT FULL NAME Charles Lester Garrett

3. (b) If veteran, name war

3. (c) Social Security No.

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) 1919 (Year)

8. AGE: Years 21 | Months 8 | Days 7 | If less than one day hr. min.

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

10. Usual occupation SCHOOL.

11. Industry or business

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

MOTHER
14. Maiden name KATE CRUSE
15. Birthplace ARK. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Kate Garrett

(b) Address 4921 PARKVIEW PL.

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

(c) Place: burial or cremation STILLWELL OKLA.

18. (a) Signature of funeral director L. M. Mullen.

(b) Address 5165 DELMAR BLVD

19. (a) OCT 14 1940 (Date received by local registrar) (b) J. F. Predeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 13 year 40 hour 10 35 minute P M.

21. I hereby certify that I attended the deceased from 9 7, 1940, to 10 - 13, 1940; that I last saw h. alive on 10 - 13, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia (Rt) Pulmonary abscess Bronchiectasis — Duration 18 months

Due to Brain abscess following pneumonia Actinomycosis, Leeds

Due to

Other conditions (Includes pregnancy within 3 months of death)

Major findings: Of operations Pulmonary abscess Brain abscess Pneumonia (Rt) Brain

Of autopsy Abscess, Pulmonary abscess.

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 Samuel A. Bachman (M.D. or coroner)

Address BARNES HOSPITAL Date signed 10-16-40

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.