

S. No. 2
-11-10-35
7-5-17-35
-1 X21492

MAR 17 1941

State File No. _____

Registration District No. 875

Primary Registration District No. 6162

Registrar's No. 44

1. PLACE OF DEATH:

(a) County Verona
(b) City or town Quincy - Washington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital #3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 yrs - 3 wks - 7 days
(Specify whether
In this community 8 yrs - 3 wks - 7 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 628 E. Grand Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME Florence Garrett

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 1
year 1941 hour 2:40 minute A.M.

3. (b) If veteran, name war WW I 3. (c) Social Security No. None

21. I hereby certify that I attended the deceased from Oct 22, 1933, to Feb 1, 1941; that I last saw rev alive on Jan 31, 1941, and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race W. 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive _____ years

Immediate cause of death Pulmonary Tuberculosis Duration 4 yrs

7. Birth date of deceased April 18 1885
(Month) (Day) (Year)

Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) 12/10

8. AGE: Years 55 Months 9 Days 14 If less than one day _____ hr. _____ min.

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

10. Usual occupation None

11. Industry or business _____

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

12. Name Joel Garrett
13. Birthplace Dart. Knox (City, town, or county) (State or foreign country)

14. Maiden name Rachel Robinson
15. Birthplace Cassville O Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Records State Hosp #3
(b) Address Verona, Mo.

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? _____

17. (a) Burial (b) Date thereof 2/4/41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St Hosp Cemetery

18. (a) Signature of funeral director Henry Samuel Horn
(b) Address Verona, Mo.

(Specify type of place) (d) Means of injury _____
23. Signature Allen V. Hays (M. D. or other) MD
Address Verona, Mo. Date signed 2-3-41

19. (a) 2-3-41 (b) Allen V. Hays
(Date received local registrar) (Registrar's signature)

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

800

MOTHER FATHER

RECEIVED
District Health Officer No. 7.
District File Number 8-41-444
Date Filed 3-6-41

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 _____

Lloyd R. Wimsatt

Licensed Embalmer No. _____

2857

P. O. Address _____

Nevada, Mo

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.