

S. N
17-10-39
5-17-39
X21492

FILED JUL 12 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 21046

Registration District No. 30

Primary Registration District No. 3003

Registrar's No. 28

1. PLACE OF DEATH:

(a) County Barry

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

(c) Name of hospital or institution:
506 Lincoln Ave.
(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 Ira Lee Garrison

8. (b) If veteran, name war _____ 8. (c) Social Security No. None

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife Etta Garrison 6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased January 24, 1879
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

62 4 29 hr. min.

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

10. Usual occupation Constable

11. Industry or business _____

12. Name John Garrison

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

14. Maiden name Sarah Davidson

15. Birthplace Lawrence Co. Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Vera Crabtree,
(b) Address Monett, Mo.

17. (a) Burial (b) Date thereof 6/24/1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Walnut Grove Cemetery

18. (a) Signature of funeral director Callaway
(b) Address Monett Mo

19. (a) 6-24-1941 (b) W. M. West
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Barry

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

(d) Street No. 506 Lincoln Ave.
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 23
year 1941 hour 6:35 minute A M.

21. I hereby certify that I attended the deceased from May 17 1941, to June 23 1941;
that I last saw him alive on June 23 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death Essential Hypertension

Due to _____

Due to _____

Other conditions Dementia of Brain
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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 Callaway (M. D. or other) MD
Address Monett Mo Date signed 6/24/41

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

54
JUL. 9 1941

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

J. P. Buchanan

Registered Apprentice No.

working under my personal supervision.

Signed *J. P. Buchanan*

Licensed Embalmer No. *3179*

P. O. Address *Monett 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 21046

Registration District No. 30

Primary Registration District No. 3003

Registrar's No. 28

1. PLACE OF DEATH:

(a) County Barry
(b) City or town Marion
(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

3. (a) PRINT FULL NAME Ma Lee Garrison
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 M

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year _____ month _____ day

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

8. AGE: Years Months Days If less than one day
62 4 29 hr. _____ 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) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

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) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 23
year 1944 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 _____

Essential Hypertension

Due to _____

Due to _____

Other conditions Glioma of Brain
(Include pregnancy within 3 months of death)

Major findings: Benign
Of operations _____

Of autopsy held

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 Edmund Smith (M. D. or other) Do

Address Marion, Mo. Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

