

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **33041**

NOV 11 1942

Registration District No. _____

Primary Registration District No. **3000**

Registrar's No. **267**

1. PLACE OF DEATH:

(a) County **Adair**
(b) City or town **Kivksville**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Grim-Smith Hospital + Clinic
(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 **Knox**
(c) City or town **Novelty (rural)**
(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 _____

3. (a) PRINT FULL NAME **Virgil Garnett**

(b) If veteran, name war _____ (c) Social Security No. _____

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

(b) Name of husband or wife _____ (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Oct - 20 - 1938**
(Month) (Day) (Year)

8. AGE: Years **3** Months **II** Days **25** If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name **Vernon Garnett**
13. Birthplace **Novelty Missouri**
(City, town, or county) (State or foreign country)
14. Maiden name **Francis Pitzer**
15. Birthplace **Cherry Box Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Vernon Garnett**
(b) Address **Novelty Mo.**

17. (a) **Burial** (b) Date thereof **Oct-17-1942**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Novelty Mo.**

18. (a) Signature of funeral director **Keth Hudson**
(b) Address **Edina Missouri**

19. (a) **10/19/42** (b) **Th. J. Wagoner**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **15th** year **1942** hour **1** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **12:30 P.M. Oct 15** 19**42** to **death** 19**42** that I last saw him alive on **Oct 15** 19**42** and that death occurred on the date and hour stated above.

Immediate cause of death **Internal injuries** Duration **1 da.**

Due to **Blow in abdomen & lower chest on right side** **1 da.**
Due to **from kick by a horse** **1 da.**

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

Major findings:

Of operations _____
Of autopsy **Unable to get parents permission**
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) **124**
(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 **George E. Ginn** (M. D. or other) **MD.**
Address **Farksville, Missouri** Date signed **10-17-42**

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

MOTHER FATHER

1047

RECEIVED

District Health Officer No. 10

District File Number 11-42-2023

Date Filed NOV - 9 1942

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 Keith Hudson

Licensed Embalmer No. 2415

P. O. Address Edina, Miss.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 33041
Registrar's No. 267

Registration District No. 1

Primary Registration District No. 3000

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Kirkville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Dr. Smith Hosp & Clinic
(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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Virgil Ray Garrett
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct Day 27 Year 1942 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____; that I first saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death: Internal injuries Duration 1 da

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced S
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: Oct 27 (Month) (Day) (Year)

8. AGE: Years 3 Months 11 Days 10 If less than one day _____ 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 _____ (City, town, or county) (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

Due to _____
Due to Blow in abdomen & lower chest on right side 1 da
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: from kick by a horse, 1/10 1 da
Of operations _____
Of autopsy _____ 175 m

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident
(b) Date of occurrence 10-14-1942
(c) Where did injury occur? Near Novelty, Mo. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? on farm
While at work? No (Specify type of place) kicked by horse (e) Means of injury
23. Signature George E. Barr (M. D. or other) MD
Address Kirkville, Mo. Date signed 12-2-42

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

SUPPLEMENTARY

MOTHER FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically.

George E. Quinn M.D.
Parkville, Mo.