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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JUL 15 1943

3018

Registration District No. 1004

Primary Registration District No. _____

Registrar's No. 121

1. PLACE OF DEATH:

(a) County Dent. Co.

(b) City or town Salem, Mo.
(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 88 years (Specify whether _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Dent. 33

(c) City or town Salem, Mo. 1
(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 Zock T. Garner

3. (b) If veteran, name war _____

3. (c) Social Security No. 1

4. Sex M. 5. Color or race O

6. (a) Single, widowed, married, divorced S.O.

6. (b) Name of husband or wife _____

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

7. Birth date of deceased 2 - 8 - 1855
(Month) (Day) (Year)

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

88 3 12 _____ hr. _____ min.

9. Birthplace Dent Co. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Dont Know

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

14. Maiden name Dont Know

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

16. (a) Informant Social Security Office

(b) Address Salem

17. (a) Burial (b) Date thereof 5-20-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cedar Grove

18. (a) Signature of funeral director Robert Hawthorn

(b) Address Salem, Mo.

19. (a) 5-20-43 (b) J. S. [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 20 day May
year 1943 hour _____ minute 7:45 A.M.

21. I hereby certify that I attended the deceased from May 2
_____, 1943, to May 20, 1943;
that I last saw him alive on May 20, 1943;
and that death occurred on the date and hour stated above.

Immediate cause of death Opoplepsy

Due to Hypertension

Due to _____

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

Major findings: Of operations _____

Of autopsy No

Duration 3 1/2 weeks

4 Months

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) (e) Means of injury

23. Signature J. V. [Signature] (M. D. or other) MD

Address Salem, Mo. Date signed 5-30-43

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

MOTHER FATHER

1117

RECEIVED

District Health Officer No. 5,

District File Number 773447

Date Filed 7-13-42

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 with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUL 15

State File No.

Registration District No. 100Primary Registration District No. 3018Registrar's No. 121

1. PLACE OF DEATH:

- (a) County Deuel
 (b) City or town Salem
 (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 88 yrs

years, months or days)

3. (a) PRINT
FULL NAMELocket Garner

3. (b) If veteran,
-
- name war.....

3. (c) Social Security
-
- No.....

4. Sex
- m
5. Color or
- (W)
6. (a) Single, widowed, married,
-
- race divorced
- S

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if
-
- alive..... years

7. Birth date of deceased
- Feb 8 1943
-
- (Month) (Day) (Year)

8. AGE: Years
- 88
- Months
- 3
- Days
- no.
- If less than one day, min.

9. Birthplace
- Deuel, Mo.
-
- (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) (Burial, cremation, or removal) (b) Date thereof.....
-
- (Month) (Day) (Year)

- (c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

- (b) Address.....

19. (a) (Date received local registrar) (b)
- Js D. [Signature]
-
- (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
- May
- day
- 10
-
- year
- 1943
- hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19.....;
-
- that I last saw him..... alive on....., 19.....;
-
- and that death occurred on the date and hour stated above.
-
- Immediate cause of death.....

Duration

- Due to.....

- Due to.....

- Other conditions.....
-
- (Include pregnancy within 3 months of death)

- Major findings:
-
- Of operations.....

- Of autopsy.....

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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..... (M. D. or other).....

- Address..... Date signed.....

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

SUPPLEMENTARY

521254