

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSSTATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED AUG 6 1943

Registrar's No. 3087

Registration District No. 149

Primary Registration District No. 1002

## 1. PLACE OF DEATH:

(a) County Jackson  
 (b) City or town Kansas City  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
General Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 15 days  
 (Specify whether  
 In this community 62 yrs  
 years, months or days)

3. (a) PRINT FULL NAME John W. Garner3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced married  
 6. (b) Name of husband or wife Bessie Garner 6. (c) Age of husband or wife if alive 51 years  
 7. Birth date of deceased June - 10 - 1881  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>62</u>	<u>1</u>	<u>2</u>	<input checked="" type="checkbox"/> hr. <input checked="" type="checkbox"/> min.

9. Birthplace Illinois (City, town, or county) (State or foreign country)10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name Marion P Garner13. Birthplace Illinois (City, town, or county) (State or foreign country)14. Maiden name Sarah Friedrich15. Birthplace Illinois (City, town, or county) (State or foreign country)16. (a) Informant Mrs Bessie Garner(b) Address 1655 Washington17. (a) Burial (b) Date thereof July-15-43  
 (Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Wk Washington18. (a) Signature of funeral director A. P. Doster(b) Address 1415 East 1519. (a) 7-14-43 (b) D. E. Brown  
 (Date received local registrar) (Registrator's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
 (c) City or town Kansas City  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 1655 Washington  
 (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 12  
 year 43 hour 5 minute 00 P.M.21. I hereby certify that I attended the deceased from  
June 27 43 to July 12 43  
 that I last saw him alive on July 12, 1943and that death occurred on the date and hour stated above.  
 Immediate cause of death Acute pulmonary infarctionDue to 1/1a

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy see above

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) (Means of injury)

23. Signature Drury R. Thom (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

**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..... *H. P. Schler* .....

Licensed Embalmer No..... *1166* .....

P. O. Address..... *1415 East 15* .....

**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.**