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4-41  
7-29  
2-28

31097

State File No. ....

FILED SEP 16 1943

Registration District No. ....

Primary Registration District No. 5041

Registrar's No. 47

1. PLACE OF DEATH:

(a) County Barry  
 (b) City or town Rural Hotchkiss, Mo.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution: \_\_\_\_\_ (Specify whether  
 In this community all his life years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Barry 5  
 (c) City or town Rural 2  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_ 0

3. (a) PRINT FULL NAME Joseph Marion Garner

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced single

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

7. Birth date of deceased December 18 1905  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>38</u>	<u>7</u>	<u>11</u>	hr. _____ min. _____

9. Birthplace Eagle Rock Missouri  
 (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

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

12. Name Frank Garner

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

14. Maiden name Ellen Well

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

16. (a) Informant Mrs. Lena Sparks

(b) Address Cassville, Missouri

17. (a) Burial (b) Date thereof July 30 1943  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Munciey

18. (a) Signature of funeral director Culver Funeral Home  
 (b) Address Cassville, Mo.

19. (a) Aug 12-1943 Grace Williams  
 (Date received at local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 29  
 year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 7-25  
 1943, to 7-29 1943  
 that I last saw him alive on 7-28 1943  
 and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy  
Abscess on left lung  
 Due to Diagnosed Cancer  
by several doctors  
 Due to by X-Ray examination  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Duration

PHYSICIAN

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

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 Dr. W. R. M. Clin (M. D. or other) 200  
 Address Cassville Date signed 8/2/43

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

1077

RECEIVED  
District Health Officer No. 6,  
District File Number 992-1046  
Date Filed SEP 13 1943

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 J. E. Culver  
Licensed Embalmer No. 3584  
P. O. Address Cassville, 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, fact should be so stated above.

Registration District No. 11 Primary Registration District No. 504

1. PLACE OF DEATH  
(a) County Barry  
(b) City or town Rural Flat creek  
(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 Joseph Marvin Garner  
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 s  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Dec 18 1900  
(Month) (Day) (Year)

8. AGE: Years 38 Months 7 Days \_\_\_\_\_  
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 \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (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 July 1943 year \_\_\_\_\_  
\_\_\_\_\_ 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 \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

MOTHER FATHER

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

31097