. S. No. 2
OM—5-42
v. 5-17-39
P I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 22 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 21549

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 465

1. PLACE OF DEATH:

(a) County GREENE

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

(c) Name of hospital or institution: Burge Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days 0 (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dallas 30

(c) City or town Buffalo - Elkland 0
(If outside city or town limits, write "RURAL") 0

(d) Street No. —
(If rural, give location)

(e) Citizen of foreign country? — (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Garrison, John Sater

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

3. (c) Social Security No. UNK.

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Della Garrison

6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased March 16 1881
(Month) (Day) (Year)

8. AGE: Years 58 ✓ 63 | Months 2 | Days 15 | If less than one day ___ hr. ___ min.

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

10. Usual occupation Farmer Retired

11. Industry or business Highway Engineer

FATHER
12. Name Sylvester Garrison
13. Birthplace Unk. ARK.
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Carolina Cheek
15. Birthplace Dallas Co 0 Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Della Garrison
(b) Address Elkland, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-5-44
(Month) (Day) (Year)
(c) Place: burial or cremation Macedonia

18. (a) Signature of funeral director [signature]
(b) Address Buffalo Mo

19. (a) 6-2-44 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 1st
year 44 hour 7:13 P.M. minute M.

21. I hereby certify that I attended the deceased from May 30, 1944, to June 1st, 1944, that I last saw him alive on June 1st, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Tuberculosis	
Due to Tick bites	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy 26a	

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?
(Specify type of place)

While at work? (e) Means of injury

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

Address Springfield, Mo. Date signed 6-2-44

(Licensed Embalmer's Statement on Reverse Side)

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 Leonard B. Jones

Licensed Embalmer No. 2508

P. O. Address Buffalo 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.