

No. 2
5-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28157

State File No. _____

FILED SEP 7 1944

Registration District No. 355

Primary Registration District No. 9057

Registrar's No. 114

1. PLACE OF DEATH:

(a) County Lawrence

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

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

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 81 yrs
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lawrence

(c) City or town Mt Vernon, Rural-55
(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 _____

3. (a) PRINT FULL NAME Frank Garner

3. (b) If veteran, name war _____

3. (c) Social Security No. none

4. Sex ♂ 5. Color or race _____

6. (a) Single, widowed, married, divorced 2

6. (b) Name of husband or wife Mary Susan Garner

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

7. Birth date of deceased Nov 29 1862
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>81</u>	<u>8</u>	<u>25</u>	hr. min.

9. Birthplace Lawrence Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER

12. Name Jim Garner

13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

14. Maiden name Caroline Moore

15. Birthplace Unknown 1
(City, town, or county) (State or foreign country)

16. (a) Informant Ana Garner

(b) Address Mt Vernon, Mo

17. (a) Burial (b) Date thereof Aug 25-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Summit Cem. Lawrence Co

18. (a) Signature of funeral director H. D. Prosser

(b) Address Mt Vernon, Mo

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 23, 1944
year _____ hour 1 minute 30 P.M.

21. I hereby certify that I attended the deceased from June 15
1944 to Aug 23 1944

that I last saw him alive on Aug 7, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Heart block Duration unknown

Due to Excitement sudden

Due to _____

Other conditions (Include pregnancy within 3 months of death) 95^a

Major findings: Of operations _____

Of autopsy _____

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) Means of injury 9

23. Signature P. A. Holmes (M. D. or other) _____

Address Mt Vernon Date signed 8-24-44

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

1338

(Licensed Embalmer's Statement on Reverse Side)

309
RECEIVED

District Health Officer No. 6,

District File Number 944-985

Date Filed SEP 5 1944

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 Max L. Fossett

Licensed Embalmer No. 4252

P. O. Address Mt. Vernon, Md

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Sept.

Registration District No. *383*

Primary Registration District No. *3037*

Registrar's No. *114*

1. PLACE OF DEATH:

(a) Country *Lawrence*
(b) City or town *Rural*
(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 *81 yr.* years, months or days)

3. (a) PRINT FULL NAME *Frank 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

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

7. Birth date of deceased *Nov. 29*
(Month) (Day) (Year)

8. AGE: Years *81* Months *8* Days *10* If less than one day, _____ min.

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

MOTHER FATHER

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) *8/29/44* (Date received local registrar) (b) *Audrey Crawford* (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 *Aug* Day *23* Year *1944* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____ 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 _____ (Includes pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTAL

28157