

FILED NOV 6 1944

State File No.

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 857

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: **Springfield Baptist Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **11 da. 0**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Cass**
(c) City or town **Branch 'Rural'**
(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 **1**

3. (a) PRINT FULL NAME **Fred Albert Garrett**

3. (b) If veteran, name war **World War I** 3. (c) Social Security No. **499-03-1427**

4. Sex **M** 5. Color or race **Wht** 6. (a) Single, widowed, married, divorced **married**

(b) Name of husband or wife **Cora Lee Garrett** 6. (c) Age of husband or wife if alive **40** years

7. Birth date of deceased **Oct 16 1897**
(Month) (Day) (Year)

8. AGE: Years **47** Months **0** Days **14** If less than one day hr. min.

9. Birthplace **Independence Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **Blacksmith**

11. Industry or business

12. Name **Albert Henry Garrett**

13. Birthplace **Bolivar Mo**
(City, town, or county) (State or foreign country)

14. Maiden name **Katherine Turner**

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

16. (a) Informant **Cora Lee Garrett**

(b) Address **Branch Mo**

17. (a) **Burial** (b) Date thereof **11-1-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Stanton Chapel, Cass Co Mo**

18. (a) Signature of funeral director **W. B. Handy**
(b) Address **Buffalo Mo**

19. (a) **10-31-44** (b) **W. B. Handy**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **30**
year **1944** hour **8** minute **20 A.M.**

21. I hereby certify that I attended the deceased from **Oct 19**
1944 to **Oct 30** 19**44**
that I last saw him alive on **Oct 29** 19**44**
and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary abscess** Duration **3 wks**

Due to **30d**

Other conditions **aneurysm of aorta - moderate, large**

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 **W. B. Handy** (M. D. or other) **MD**
Address **Springfield, Mo** Date signed **12/30/44**

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

JAN 12 1945

DEC 15 1944

DEC 22 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 Miss B. Jones
Licensed Embalmer No. 4322
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.