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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 39342

FILED JAN 15 1945 Registration District No. 2518 Primary Registration District No. 10 Registrar's No. 11320

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

1. PLACE OF DEATH:

(a) County
(b) City or town St. Louis (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution 1314a R.N. 15th St. (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 251
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 1314a R.N. 15th St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Maynard Garner
3. (b) If veteran, name war No
3. (c) Social Security No. Unk.
4. Sex Male
5. Color or race Col
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Unk.
6. (c) Age of husband or wife if alive Unk. years
7. Birth date of deceased Abt 1895 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
Abt. 49			hr. min.

9. Birthplace (City, town, or county) Arkansas (State or foreign country)
10. Usual occupation Laborer
11. Industry or business Wabash Ry.
FATHER
12. Name Henry Garner
13. Birthplace (City, town, or county) Unk. (State or foreign country)
MOTHER
14. Maiden name Lizzie (Unk)
15. Birthplace (City, town, or county) Unk. (State or foreign country)
16. (a) Informant Lillian Cage
(b) Address 1314a R.N. 15th St.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/4/44 (Month) (Day) (Year)
(c) Place: burial or cremation McCory, Ark
18. (a) Signature of funeral director R.M.C. Green
(b) Address 3517 Laclede ave.
19. (a) JAN 3 1945 (Date received local registrar) (b) J.F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 29 year 1944 hour 8:35 minute P M.
21. I hereby certify that I attended the deceased from 11-15, 1944, to 12-12, 1944; that I last saw him alive on 12-12, 1944; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary Occlusion	Terminal
Due to Hypertensive Heart Disease	Unknown
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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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 S.E. [signature] (M. D. or other)
Address 11 N. Jefferson Date signed 1-2-44

(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 A. M. Green

Licensed Embalmer No. 1173

P. O. Address 3577 Laclede Ave

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.