

OFFICE OF THE REGISTRAR
FILED FEB 10 1945

Registration District No. 314

Primary Registration District No. 606-74459

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St. Clair

(b) City or town Orcutt
(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 27 years! (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Clair

(c) City or town Orcutt 93
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) 2

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

If yes, name country _____

3. (a) PRINT FULL NAME Cora L. Garfield

3. (b) If veteran, name war no

3. (c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 26
year 1945 hour 9 minute 15 A.M.

21. I hereby certify that I attended the deceased from 1-20-45
_____ 19____ to 1-26 1945
that I last saw her alive on 1-26 1945
and that death occurred on the date and hour stated above.

4. Sex female 5. Color or race white

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

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

7. Birth date of deceased May 10 1861
(Month) (Day) (Year)

Immediate cause of death mitral insufficiency

Duration short

8. AGE: Years 83 Months 8 Days 16

If less than one day _____ hr. _____ min.

Due to _____

Due to _____ 92 1/2

9. Birthplace Wellington Ohio!
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) _____

10. Usual occupation Housekeeping

11. Industry or business _____

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name Leverett H. Trowbridge

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

14. Maiden name Sarah Ann Smith

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

16. (a) Informant Marion Garfield

(b) Address Orcutt, Mo.

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? _____

17. (a) Burial (b) Date thereof Jan 29 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dunkard Cemetery

While at work _____ (Specify type of place)

(e) Means of injury _____

18. (a) Signature of funeral director Orcutt Funeral Home

(b) Address Orcutt, Missouri

19. (a) Feb. 8 1945 (b) L. B. Goodrich
(Date received local registrar) (Registrar's signature)

23. Signature Ruth Seaton (M. D. or other) _____

Address Orcutt, Mo. Date signed 2-8-45

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

3
2
0

No. 7.
1-45-103
Date Filed 2-9-45

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 Paul Finckler

Licensed Embalmer No. 3990

P. O. Address Oskaloosa

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.