

FILED AUG 13 1945 STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3194

1. PLACE OF DEATH:

(a) County Jackson,
(b) City or town Kansas City,
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
43 West 58th Terrace
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution no.
(Specify whether
In this community all his life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City,
(If outside city or town limits, write "RURAL")
(d) Street No. 43 West 58th Terrace,
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country X

3. (a) PRINT FULL NAME Robert Bowers Garrett

3. (b) If veteran, name war no. 3. (c) Social Security No. 487-09-7932

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Dorothy Oldham Garrett 6. (c) Age of husband or wife if alive 58 years
7. Birth date of deceased September 16 1888
(Month) (Day) (Year)

8. AGE: Years 56 Months 10 Days 13 If less than one day hr. min.

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

10. Usual occupation Retired

11. Industry or business X

12. Name Samuel Garrett
13. Birthplace Kansas (City, town, or county) (State or foreign country)
14. Maiden name Letitia Bowers
15. Birthplace Pennsylvania (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Dorothy Oldham Garrett,
(b) Address 43 W. 58th Ter., Kansas City, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-31-45 (Month) (Day) (Year)
(c) Place: Burial or cremation Seavenworth to Mount Muncie Cemetery
Stine & McClure,

18. (a) Signature of funeral director
(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 7-30-45 (Date received local registrar) (b) Sheldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 29 year 1945 hour 5:00 minute A. M.

21. I hereby certify that I attended the deceased from May 21 1945 to July 29 1945
that I last saw him alive on July 28 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Haemorrhage Duration 2 weeks
Due to High P.B. from Bright Disease 8 mo
Infected teeth 2 mo
year

Other conditions (Include pregnancy within 3 months of death)
Major findings: 13/15
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 D.P. Klehner M.D. (M. D. or other)
Address 615 N. 1st Bldg. K.C. Mo. Date signed 7/30/45

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

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Dr. D. P. Klepinger

*Angyle
D. Bledy*

// A.M.C.

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.....

.....
working under my personal supervision.

....., Registered Apprentice No.

Signed

[Handwritten Signature]
.....
Licensed Embalmer No. *1415*
P. O. Address *Y. C. M. D.*

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.