DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24680

FILED AUG 9 1945

Registration District No. 275

Primary Registration District No. 3053

Registrar's No. 89

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

1. PLACE OF DEATH:
(a) County Phelps
(b) City or town Rolla
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Nelle McFarland Memorial Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 Days (Specify whether
In this community 10 Days years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County 32
(c) City or town Montauk
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Sandra Sue Garrison
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Female 1
5. Color or race W
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Jan (Month) 20 (Day), 1943 (Year)

8. AGE: Years 2 | Months 5 | Days 13 | If less than one day hr. min.

9. Birthplace Montauk, (City, town, or county) Mo. 0 (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER
12. Name Sanford Garrison
13. Birthplace Raymondville Mo. 0 (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Thelma Cummins
15. Birthplace Raymondville Mo. 0 (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) 7-28-45 (Date received local registrar) (b) Mrs. Juanita Harvey (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 3rd year 1945 hour 5 minute 15a M.
21. I hereby certify that I attended the deceased from June 23, 1945 to July 3rd 1945 that I last saw her alive on July 3rd 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Non specific meningitis.

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 23
(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 [signature] (M. D. or other)
Address Rolla Mo Date signed 7/3/45

140

(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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 28
5M—3-45
I X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Aug

Registration District No. 275 Primary Registration District No. 3053 Registrar's No. 89

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

1. PLACE OF DEATH:
(a) County Phelps
(b) City or town Rolla
(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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME Sandra Sue Garrison
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Jan (Month) 20 (Day) 1943 (Year)

8. AGE: Years 2 Months 5 Days 3 If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business

MOTHER FATHER
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 Sanford Garrison
(b) Address Montauk, Mo.
17. (a) (Burial) (Burial, cremation, or removal) (b) Date thereof July 4, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Ashley Creek Cem.
18. (a) Signature of funeral director Smith & Ferguson
(b) Address Licking, Mo.
19. (a) July 28, 1945 (Date received by local registrar) (b) Mrs Juanita Harvey (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day year 1945 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19;
that I last saw h alive on 19;
and that death occurred on the date and hour stated above.
Immediate cause of death Fractured skull due to a fall

Duration

Due to
Due to
Other conditions (Include 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) Accident
(b) Date of occurrence 6-23-45
(c) Where did injury occur? Montauk, Dent Mo. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home. (Specify type of place)
While at work? Place (e) Means of injury
23. Signature A. Sidney McFarland (M. D. or other)
Address Rolla Date signed 12-5-45

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY REGISTRATION REQUIRED

5-24680