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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 7 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27200**

Registration District No. **82** Primary Registration District No. **3017** Registrar's No. **92**

1. PLACE OF DEATH:
(a) County **Cooper-**
(b) City or town **Boonville, Mo**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St Josephs Hospital - 1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **11-days**
In this community **11-days-**
years, months or days

3. (a) PRINT FULL NAME **Caroline Ann Garner.**
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex **Female** 5. Color or race
6. (a) Single, widowed, married, divorced **single**
6. (c) Age of husband or wife if alive **-** years
7. Birth date of deceased **Aug- 28- 1945**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day **1:00 hr. min.**

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

10. Usual occupation **Infant**

11. Industry or business **"**

12. Name **James D. Garner.**
13. Birthplace **Armstrong, Missouri**
(City, town, or county) (State or foreign country)
14. Maiden name **Ellen-Marie-Engle**
15. Birthplace **Fount- Kentucky**
(City, town, or county) (State or foreign country)

16. (a) Informant **James D. Garner.**
(b) Address **Armstrong, Mo**
17. (a) **Burial** (b) Date thereof **8-28-45**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Armstrong Cem-**

18. (a) Signature of funeral director **A. H. Oldaker.**
(b) Address **Armstrong - Mo**
19. (a) **8-28-45** (b) **Dr Chas. Swapp**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri-** (b) County **Howard 45**
(c) City or town **Armstrong Rural 1**
(If outside city or town limits, write "RURAL")
(d) Street No. **R.F.D. Box # 212 0**
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Aug** day **28-**
year **1945** hour **1:00** minute **P. M.**
21. I hereby certify that I attended the deceased from **Aug 28**, 19 **45** to **Aug 28**, 19 **45**
that I last saw her alive on **Aug 28**, 19 **45**
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Pyelo Nephritis & Subsequent Toxemia**
Due to **-**
Due to **-**
Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations
Of autopsy **133a**

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 H Ziegler** (M. D. or other)
Address **Boonville Mo** Date signed **8-28-**

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

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

MOTHER FATHER

1088

(Licensed Embalmer's Statement on Reverse Side)

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.

Not Embalmed

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.

Registration District No. 82 Primary Registration District No. 3017 Registrar's No. 92

1. PLACE OF DEATH:

(a) County Cooper
 (b) City or town Proville
(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 11 days
(Specify whether years, months or days)
 In this community 11 days

3. (a) PRINT FULL NAME Carolina G. Garner
 3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex F 5. Color or race white 6. (a) Single, widowed, married, divorced S
 6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive 56
 7. Birth date of deceased Aug 28 1928
(Month) (Day) (Year)

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

9. Birthplace.....
(City, town, or county) (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.....
 (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) (Date received local registrar) (b) (Registrar's signature)

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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day 28 Year 1983 hour..... minute..... M.
 21. I hereby certify that I attended the deceased from..... to....., 19.....
 that I last saw him..... on..... and that death occurred on the date and hour stated above.
 Immediate cause of death.....

Due to.....
 Due to.....
 Other conditions.....
(Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings:
 Of operations.....
 Of autopsy.....
 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..... (M. D. or other)
 Address..... Date signed.....

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

SUPPLEMENTARY

S-27200

