

U.S. No. 2
 FORM-5-43
 Rev. 5-17-39
 I X38671

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH
 1003

State File No. **29031**
 Registrar's No. **8047**

FILED SEP 21 1945
 318

Registration District No. _____ Primary Registration District No. _____

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:
Missouri Baptist Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community _____
years, months or days)

3. (a) PRINT FULL NAME Cora Garrett
 3. (b) If veteran, name war Nil
 3. (c) Social Security No. None

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Louis Garrett
 6. (c) Age of husband or wife if alive 55 years
 7. Birth date of deceased July 16 1895
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
50 1 27 _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____
 12. Name Thomas Doolin
 13. Birthplace Thomsonville Illinois
(City, town, or county) (State or foreign country)
 14. Maiden name Cynthia Paterson
 15. Birthplace Harrisburg Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Louis Garrett
 (b) Address 2503 Howard St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-15-45
(Month) (Day) (Year)

(c) Place: burial or cremation Friedens Cemetery

18. (a) Signature of funeral director Albert H. Hoppe
 (b) Address 4700 Washington Blvd.

19. (a) SEP 14 1945 (b) J. F. Beadeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County 000
 (c) City or town St. Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 2503 Howard St.
(If rural, give location)
 (e) Citizen of foreign country? 0 (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 13
 year 1945 hour 5:45 minute A. M.

21. I hereby certify that I attended the deceased from 9-1-45 19, to 9-13-45 19;
 that I last saw h. in alive on 9-13-45 19;
 and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis
due to myocardial infarction
 Due to Myocardial infarction

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

Major findings:
 Of operations _____
 Of autopsy _____

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 R. K. ... (M. D. or other) 9-14-45
 Address 4932 M. O. ... Date signed _____

Duration

 PHYSICIAN

 Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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.....

John G. Moske

Licensed Embalmer No..... *3398*

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.