

**FILED** APR 10 1946

Registration District No. 76

Primary Registration District No. 6290

Registrar's No. 19

**1. PLACE OF DEATH:**

(a) County Dallas  
(b) City or town Buffalo rural  
(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) 1  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 4 yrs years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Dallas <sup>30</sup>  
(c) City or town Buffalo rural <sup>0</sup>  
(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 U

3. (a) PRINT FULL NAME JOHN RUSSELL GARRET

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Donna 6. (c) Age of husband or wife if alive 34 years  
7. Birth date of deceased Aug 16 1888  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
57 6 20 hr. min.

9. Birthplace Wicks Creek Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Opus Garrett  
13. Birthplace Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Sarah Jane Russell  
15. Birthplace Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Donna Garrett  
(b) Address Buffalo Mo

17. (a) Burial (b) Date thereof 3-8-46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Paragon Grove

18. (a) Signature of funeral director B. B. Jones  
(b) Address Buffalo Mo

19. (a) 4-2-1946 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Mar day 6  
year 1946 hour \_\_\_\_\_ minute 25 a.m.

21. I hereby certify that I attended the deceased from 2-2-46  
\_\_\_\_\_ 19\_\_\_\_ to 3-6- 1946  
that I last saw him alive on 2-28 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Suffering Duration 3 weeks  
Chronic Arthritis 17 yrs  
Due to unknown  
Pneumonia 3 weeks  
Other conditions Starvation  
(Include pregnancy within 3 months of death)

Major findings: Of operations None Of autopsy None  
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED \_\_\_\_\_  
Physician's signature \_\_\_\_\_  
Physician's name \_\_\_\_\_  
Physician's address \_\_\_\_\_  
Physician's telephone number \_\_\_\_\_  
Physician's title \_\_\_\_\_  
Physician's specialty \_\_\_\_\_  
Physician's license number \_\_\_\_\_  
Physician's expiration date \_\_\_\_\_  
Physician's hospital affiliation \_\_\_\_\_  
Physician's hospital address \_\_\_\_\_  
Physician's hospital telephone number \_\_\_\_\_  
Physician's hospital license number \_\_\_\_\_  
Physician's hospital license expiration date \_\_\_\_\_

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 B. B. Jones (M. D. or other) MD  
Address Buffalo Mo Date signed 3-27-46

RECEIVED  
District Health Officer No. 7,  
District File Number 3-46-362  
Date Filed 4-12-46

**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 Miss B. Jones  
Licensed Embalmer No. 4322  
P. O. Address Buffalo, Mo

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

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

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. April  
Registrar's No. 19

Registration District No. 96 Primary Registration District No. 6290

1. PLACE OF DEATH:  
(a) County Dallas  
(b) City or town Buffalo Rural  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME John P. Lanett  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Aug 16 (Month) (Day) (Year)

8. AGE: Years 57 Months 6 Days \_\_\_\_\_ (If less than one day, hr. min.)  
9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) MO

10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_  
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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal) (Specify type of place)  
(c) Place: burial or cremation \_\_\_\_\_  
18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_  
19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (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 Mar year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
Due to Lobar Pneumonia 3 days  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy 108

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 \_\_\_\_\_

SUPPLEMENTARY

MOTHER FATHER

2845

8916