

No. 2
-1-4-41
-17-39
X2839

State File No.

Registrar's No.

FILED MAY 13 1946
Registration District No. 128

Primary Registration District No. 5406

1. PLACE OF DEATH:

(a) County **GREENE**
(b) City or town **Springfield Rural - S. Campbell Twp.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Ozark Osteopathic Hosp. O.**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **yes** years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Greene 29**
(c) City or town **Republic - Rural 0**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) **0**
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Thomas W. Garoutte**

3. (b) If veteran, name war **UNK.** 3. (c) Social Security No. **None**

4. Sex **Male 0** 5. Color or race **White American**
(a) Single, widowed, married, divorced **WIDOWER**

6. (b) Name of husband or wife **itim. UNK.** 6. (c) Age of husband or wife if alive **Dec.** years

7. Birth date of deceased **Apr. 1 1861**
(Month) (Day) (Year)

8. AGE: Years **85** Months **0** Days **20** If less than one day hr. min.

9. Birthplace **Greene Co. Mo. 0**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

MOTHER FATHER { 12. Name **Thomas W. Garoutte**

13. Birthplace **Greene Co. Mo. 0**
(City, town, or county) (State or foreign country)

14. Maiden name **Sarah E. Garoutte - Rasmussen**

15. Birthplace **Greene Co. Mo. 0**
(City, town, or county) (State or foreign country)

16. (a) Informant **MRS. Mattie Gann**

(b) Address **Republic, Mo.**

17. (a) **Burial** (b) Date thereof **Apr. 27 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Garoutte Cemetery**

18. (a) Signature of funeral director **T. G. Thurman Ltd Co.**

(b) Address **Republic Mo.**

19. (a) **Apr. 27 1946** (b) **A. W. Hurdley**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Apr.** day **21** year **1946** hour **11** minute **25** A.M.

21. I hereby certify that I attended the deceased from **Apr 20** to **Apr 21** 19**46** and that death occurred on the date and hour stated above.
that I last saw him alive on **Apr 21** 19**46**

Immediate cause of death **Cerebral concussion**
Due to **Fractured skull**
Due to **Gunshot wound**

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations **164**
Of autopsy _____

Duration
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) **Suicide**

(b) Date of occurrence **4-20-46**

(c) Where did injury occur? **Republic Greene Mo**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **home**

While at work? **No** (Specify type of place) (c) Means of injury **22 Rifle**

23. Signature **R. C. Michael D.D.** (other) **2**
Address **Springfield Mo.** Date signed **4-21-46**

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

111

104

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 ~~Edgar~~

Elmer M. Hunsicker, Registered ^{Embalmer} Apprentice No. 3687
working under my personal supervision.

Signed Elmer M. Hunsicker

Licensed Embalmer No. 509

P. O. Address Republic

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.

X