

FILED APR 22 1946
STANDARD CERTIFICATE OF DEATH

State File No. **13856**Registration District No. **209**Primary Registration District No. **3043**Registrar's No. **135**

1. PLACE OF DEATH

(a) County **Marion**
 (b) City or town **Marion**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
1252 Lyon St /
 (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 **Alpha B. Garrico**3. (b) If veteran, name war **World War II** 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 **Mary** 6. (c) Age of husband or wife if alive **26** years
 7. Birth date of deceased **March 18 1903**
 (Month) (Day) (Year)

8. AGE: Years **44** Months **-** Days **13** If less than one day hr. _____ min. _____

9. Birthplace **Marion, MO**
(City, town, or county) (State or foreign country)10. Usual occupation **Anderson Produce Co**

11. Industry or business

MOTHER FATHER
 12. Name **Richard Garrico**
 13. Birthplace **Marion Co MO**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Mary Specker**
 15. Birthplace **Marion, MO**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Mary Garrico**(b) Address **1252 Lyon St. Marion MO**17. (a) **Burial** (b) Date thereof **April 3 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation **MT-Olivet Cem**18. (a) Signature of funeral director **James O'Donnell**(b) Address **Marion MO**19. (a) **4-5-46** (b) **Dr. E. M. Lucke**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Marion** **64**
 (c) City or town **Marion** ?
 (If outside city or town limits, write "RURAL")
 (d) Street No. **1252 Lyon** 4
 (If rural, give location) 0
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **31st**
year **1946** hour _____ minute **12:20 AM**21. I hereby certify that I attended the deceased from **Mar 31 1946** to **Mar 31 1946**
that I last saw him alive on **March 31 1946**
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Head on arrival at this**have**Due to **Coronary Disease of Heart from History**Due to **given by family**Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:

Of operations **gfu**

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) _____
 (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 **W P Birney** (M. D. or other) **MD**
Address **Marion MO** Date signed **4-5-46**

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..... *H M O'Connell*

Licensed Embalmer No. *3889*

P. O. Address *Stannibal Mo*

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. 209 Primary Registration District No. 3043

1. PLACE OF DEATH:
(a) County Marion
(b) City or town Humboldt
(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 _____ years, months or days

3. (a) PRINT FULL NAME Alpha B Carrico
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 W

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: Mar 18 _____ (Month) (Day) (Year)

8. AGE: Years 44 Months _____ Days _____ (If less than one day, hr. _____ min. _____)

9. Birthplace _____ (City, town, or county) (State or foreign country) MO

10. Usual occupation Western Producers

11. Industry or business (Owner) manager of Co.

12. Name for 3 years

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____ (City, town, or county) (State or foreign country)

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)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) E. M. Lucke
(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 31
year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive 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)

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)
(c) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

MOTHER, FATHER

TEMPORARILY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

13856