DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 19101

FILED MAY 16 1946

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 68

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

1. PLACE OF DEATH:
(a) County Saline
(b) City or town Marshall
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Fitzgibbons Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 15 Hours (Specify whether
In this community All her life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Saline 97
(c) City or town Marshall 1
(If outside city or town limits, write "RURAL")
(d) Street No. 855 East Eastwood 2
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Helen Mae Garner
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Female 1
5. Color or race White
6. (a) Single, widowed, married, divorced Divorced 2
6. (b) Name of husband or wife Charles B. Garner
6. (c) Age of husband or wife if alive 31 years
7. Birth date of deceased August 9th, 1918 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
27	8	2	hr. min.

9. Birthplace Saline county (City, town, or county) Missouri (State or foreign country) 0
10. Usual occupation Housewife
11. Industry or business
FATHER
12. Name Scott Johnson
13. Birthplace Saline county (City, town, or county) Missouri (State or foreign country) 0
MOTHER
14. Maiden name Lucy Mae Scott
15. Birthplace Cole county, (City, town, or county) Missouri (State or foreign country) 0
16. (a) Informant Charles B. Garner
(b) Address 612 N-Franklin, Marshall, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 13, 1946 (Month) (Day) (Year)
(c) Place: burial or cremation Ridge Park cemetery
18. (a) Signature of funeral director Campbell-Lewis
(b) Address Marshall, Missouri
19. (a) 4-13-46 (Date received local registrar) (b) Mrs T. O. Westbrook (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 11
year 1946 hour 10 minute A M.
21. I hereby certify that I attended the deceased from Oct 2, 1944, to April 1, 1946
that I last saw her alive on Apr 11, 1946
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Diabetic Coma	24 hrs
Due to Diabetes Mellitus	24 yrs
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
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 0
23. Signature [signature] M.P. (M. D. ~~or other~~)
Address Marshall Mo Date signed 4-12-46

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(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 5/5/46

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 R. W. Campbell Jr.

Licensed Embalmer No. 3469

P. O. Address Marshall, 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. June

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 68

1. PLACE OF DEATH:

(a) County Saline

(b) City or town Marshall
(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)

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

3. (a) PRINT FULL NAME Helen M. Garner

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced Div

6. (b) Name of husband or wife

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

7. Birth date of deceased Aug (Month) 9 (Day) 1918 (Year)

8. AGE: Years 27 Months 8 Days 2 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business Home.

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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) Mrs T. Weschoot (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month April day 1 year 1946 hour minute M.

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

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations

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 (M. D. or other)

Address Date signed

SUPPLEMENTARY

19101