

**FILED** JUL 8 1948

State File No. \_\_\_\_\_  
 Registrar's No. 135

Registration District No. \_\_\_\_\_ Primary Registration District No. 3019

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

1. PLACE OF DEATH:

(a) County Dunklin

(b) City or town Kennett Independence

(c) Name of hospital or institution:  
Presnell Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 hours  
(Specify whether years, months or days)

In this community 8 hours  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Dunklin

(c) City or town Kennett  
(If outside city or town limits, write "RURAL")

(d) Street No. Presnell Hospital  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Aline 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 \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased: 6 4 46  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

8 hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER {

12. Name Vernon E. Garner

13. Birthplace D K Tenn  
(City, town, or county) (State or foreign country)

14. Maiden name Loreane Ray

15. Birthplace Holcomb Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant James Ray

(b) Address Holcomb Mo R# I

17. (a) Burial (b) Date thereof 6 5 46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pine City Cem

18. (a) Signature of funeral director Lentz Und Co

(b) Address Kennett Mo

19. (a) 6-18-46 (b) Carl Husband  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 4  
 year 1946 hour 7 minute 30 P. M.

21. I hereby certify that I attended the deceased from 6-4 1946 to 6-4 1946  
 that I last saw h. SR alive on 6-4 1946  
 and that death occurred on the date and hour stated above.

Immediate cause of death Congenital heart disease

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings:  
 Of operations \_\_\_\_\_

Of autopsy 1572

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) \_\_\_\_\_

(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) (a) Means of injury \_\_\_\_\_

23. Signature J. C. Wilson (M.-D. or other) \_\_\_\_\_  
 Address Kennett Mo Date signed 6-18-46

RECEIVED

District Health Office No. 2

District File Number 746-77

Date Filed 7-3-46

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**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.....

Licensed Embalmer No.....

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.**