

S. No. 2
OM-2-43
v. 5-17-39
I X35697

25952

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 6

FILED AUG 1 1946
Registration District No. 3-31

Primary Registration District No. _____

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

1. PLACE OF DEATH:
(a) County Scott
(b) City or town Commerce, Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
R#1, South of Commerce
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years/months or days)
In this community 17 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Scott
(c) City or town Commerce, Rural
(If outside city or town limits, write "RURAL")
(d) Street No. R#1, South of Commerce
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Bertha Myrtle Garrett
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 10th
year 1946 hour 1:00 minute 6 A.M.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, Married
6. (b) Name of husband or wife Oscar Garrett 6. (c) Age of husband or wife if alive 47 years
7. Birth date of deceased October 2, 1910
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 9, 1946 to July 10, 1946
that I last saw her alive on July 10, 1946
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>35</u>	<u>9</u>	<u>8</u>	hr. _____ min. _____

Immediate cause of death Post-partum Hemorrhage
Due to Atony of the Uterus

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

Due to _____
Other conditions low insertion of Placenta
(Include pregnancy within 3 months of death)

10. Usual occupation Housewife

Major findings:
Of operations _____
Of autopsy 146

11. Industry or business None
12. Name William Henry Cross

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

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

15. Birthplace Bollinger Co., Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Oscar Garrett
(b) Address R#1, Commerce, Mo.

17. (a) Burial (b) Date thereof July 12, 1946
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Commerce Cemetery

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

18. (a) Signature of funeral director Joe R. Nunnally
(b) Address Charleston, Missouri
19. (a) 7-22-46 (b) Addie Held
(Date received local registrar) (Registrar's signature)

(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. P. Bryan (M. D. or other) D.O.
Address Benton, Mo. Date signed 7-12-46

297

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RECEIVED

RECEIVED

District

Date

District Health Office No. 2,

District File Number 246-9254

Date Filed 8/1/46

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 Edward E. Munnell

Licensed Embalmer No. 4164

P. O. Address Charleston, W. Va.

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. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH: Scott
 (a) County Scott
 (b) City or town Commerce, Miss
 (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 Bertha Garrett
 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 mar
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 35 Months _____ Days _____ (If less than one day) hr. _____ min.

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

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) _____ (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) Addie Held (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 July 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 _____

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

Major findings:
 Of operations _____
 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) _____
 (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) (g) Means of injury _____
 23. Signature D. P. Broughton (M. D. or other) DO.
 Address Boston, Mo. Date signed _____

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

SUPPLEMENTARY

25952