

FILED FEB 14 1947

Registration District No. 128

Primary Registration District No. 2000

State File No.

Registrar's No. 84

1. PLACE OF DEATH:
 (a) County Greene
 (b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
449 South 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 12 Years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Greene ³⁹
 (c) City or town Springfield ²
(If outside city or town limits, write "RURAL")
 (d) Street No. 449 South ⁴
(If rural, give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3. (a) PRINT FULL NAME Catherine Jane Garrett
 3. (b) If veteran, name war No 3. (c) Social Security No. No

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Jan. day 26
 year 1947 hour 10 minute 30a. M.
 21. I hereby certify that I attended the deceased from Jan 8, 1947
 to Jan 26, 1947
 that I last saw h. ex alive on Jan 25, 1947
 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced, Widowed
 6. (b) Name of husband or wife John Garrett
 6. (c) Age of husband or wife if alive Dec. years
 7. Birth date of deceased Nov. 25 1848
(Month) (Day) (Year)

Immediate cause of death Chronic Myocarditis several years
 Duration several years
 Due to

8. AGE: Years 98 Months 2 Days 1
 If less than one day hr. min.

Due to

9. Birthplace Cass County Indiana 1
(City, town, or county) (State or foreign country)
 10. Usual occupation Home

Other conditions Fracture of right femur 18 days
(Include pregnancy within 3 months of death)
 Major findings:
 Of operations
 Of autopsy
PHYSICIAN
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED STATISTICALLY.

MOTHER FATHER
 12. Name Samuel Black
 13. Birthplace Fairfield County Ohio
(City, town, or county) (State or foreign country)
 14. Maiden name Margaret Black
 15. Birthplace Delaware County Ohio
(City, town, or county) (State or foreign country)

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) (e) Means of injury

16. (a) Informant Mrs. Margaret Jarrett
 (b) Address Springfield, Mo.
 17. (a) Burial (b) Date thereof 1/28/47
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Lamar, Mo.
 18. (a) Signature of funeral director H.H. Lohmeyer
 (b) Address Springfield, Mo.
 19. (a) 1-27-47 (b) H.S. Handley md
(Date received local registrar) (Registrar's signature)

23. Signature O.C. Horst (M. D. or other) M.D.
 Address 430 South Ave Date signed 1/27/47

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 *Walter E. Fenwick*

Licensed Embalmer No. *3808*

P. O. Address *Springfield, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above..

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7884

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(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 years, months or days)

3. (a) PRINT FULL NAME Catherine J. Garret

3. (b) If veteran, name war _____ (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased Nov 25 (Month) (Day) (Year)

8. AGE: Years 98 Months 2 Days _____ If less than one day hr. _____ min. _____

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

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) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (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 _____ Day _____ Year 1947 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 _____

Duration

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) Accident

(b) Date of occurrence Jan 7, 1947

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

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

While at work? No (Specify type of place) (e) Means of injury fall

23. Signature O.G. Horst M.D. (M. D. or other)

Address 430 1/2 West Springfield Mo Date signed 1/15/47

SUPPLEMENTARY

MOTHER FATHER

S-785