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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 6 1947
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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 845

Registration District No. _____ Primary Registration District No. 2000

1. PLACE OF DEATH: **GREENE**
(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: **City Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **36 Hours**
In this community **all her life** (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. **610 W. Dale Street** **6**
(If rural, give location) **0**
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Myrtle J. Garrett**
3. (b) If veteran, name war **none** 3. (c) Social Security No. **none**
4. Sex **female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **widowed**
6. (b) Name of husband or wife **Elisha Garrett** 6. (c) Age of husband or wife if alive **deceased** years
7. Birth date of deceased **August 31, 1875**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **September** day **25th**
year **1947** hour **1:30 A.M.** minute _____ M.
21. I hereby certify that I attended the deceased from **8-4**, 1947, to **8-31**, 1947.
that I last saw her alive on **8-30**, 1947,
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
72 0 24 hr. min.

Immediate cause of death
Carcinoma of Intestine
Due to _____
Due to _____

9. Birthplace **Springfield, Missouri**
(City, town, or county) (State or foreign country)
10. Usual occupation **none**
11. Industry or business **none**

Other conditions (Include pregnancy within 3 months of death)
Major findings: **46E**
Of operations _____
Of autopsy _____

MOTHER, FATHER {
12. Name **John H. Doran**
13. Birthplace **unknown Tennessee**
(City, town, or county) (State or foreign country)
14. Maiden name **Jane Mitchell Kentucky**
15. Birthplace **unknown Kentucky**
(City, town, or county) (State or foreign country)

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

16. (a) Informant **L.B. Garrett**
(b) Address **728 S. Missouri, Springfield, Mo.**
17. (a) **burial** (b) Date thereof **Sept. 28, 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Robderson Prairie**

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? _____

18. (a) Signature of funeral director **Thieme**
(b) Address **Springfield, Mo.**
19. (a) **9-27-47** (b) **W.E. Hanchey, M.D.**
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place) (c) Means of injury **0**
23. Signature **W.E. Hanchey, M.D.** (M. D. or other)
Address **221 1/2 E. Commercial** Date signed **9-27-47**

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

3681 1 3681

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..... *Ralph H. Triema*

Licensed Embalmer No. 3681

P. O. Address..... Springfield, 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.