

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 28 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40748

Registration District No. 374

Primary Registration District No. 6274

Registrar's No. 71

1. PLACE OF DEATH:

(a) County Worth
(b) City or town Rural-Middlefork
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community 41 years
years, months or days)

3. (a) PRINT FULL NAME Joseph Lafe Garrett

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Ida Mae Garrett 6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased 8 (Month) 22 (Day) 1867 (Year)

8. AGE: Years 80 Months 2 Days 18 If less than one day hr. min.

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

10. Usual occupation farming

11. Industry or business

12. Name John Garrett
13. Birthplace unknown Indiana
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Devorce

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

16. (a) Informant Mrs. Maudie Mobley

(b) Address Benton, Iowa.

17. (a) Burial (b) Date thereof 11-12-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grant City, Mo.

18. (a) Signature of funeral director Arch C. Dwyer

(b) Address Grant City, Mo.

19. (a) Nov. 17-1947 (b) Leta E. Dawson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Worth
(c) City or town Rural
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 10
year 1947 hour 7 minute 45 P. M.

21. I hereby certify that I attended the deceased from 10-20-47
to 11-4-47
that I last saw him alive on 11-4-47
and that death occurred on the date and hour stated above.

Immediate cause of death Ca. Bladder Duration 7 mos.

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) (c) Means of injury

23. Signature Frank A. Ross (M. D. or other)

Address Albany, Mo. Date signed 11-11-47

(Licensed Embalmer's Statement on Reverse Side)

DISTRICT HEALTH OFFICE
Cameron, Mo.

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.....

Arch C. Dunfee

Licensed Embalmer No. *3252*

P. O. Address *Grant City 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.