

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29767
Registrar's No. 3672

Registration District No. 1948/9

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days
In this community about 35 years (Specify whether years, months or days)

3: (a) PRINT FULL NAME John R. Garrison
3. (b) If veteran, name war None 3. (c) Social Security No. Unknown

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

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

7. Birth date of deceased Feb. 1869
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
79 7 ? _____ hr. _____ min.

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

10. Usual occupation Pensioner

11. Industry or business _____

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Record Clerk

(b) Address K.C. General Hosp. #1

17. (a) Burial (b) Date thereof 9-10-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Weilert Funeral Home
(b) Address 2332 Monitor Place: K.C. Mo.

19. (a) 9-8-48 (b) Thelma Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 728 Cambridge
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 2
year 1948 hour 7 minute 35 A.M.

21. I hereby certify that I attended the deceased from Aug. 31, 1948, to Sept. 2, 1948;
that I last saw him alive on Sept. 2, 1948;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Bronchopneumonia

Due to _____

Due to _____

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

Major findings: 107
Of operations _____

Of autopsy None

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 _____

23. Signature Wm W Hart (M.D. or other) _____
Address Med. Dir. Gen'l Hosp. Date signed 9-3-48

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Dr. Hunt

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 *Blaine E. Weibert*

Licensed Embalmer No. *4075*

P. O. Address *K.C. 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.