No. 300
—10-47
5-17-39
I-3906

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED DEC 9 1948

Registration District No. 175

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 37224

Primary Registration District No. 3036

Registrar's No. 103

1. PLACE OF DEATH:

(a) County: Lawrence

(b) City or town: Aurora
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 114 W. St. Louis St.
(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: Years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Lawrence

(c) City or town: Aurora
(If outside city or town limits, write "RURAL")

(d) Street No.: 114 W. St. Louis St.
(If rural, give location)

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

If yes, name country: ____

3. (a) PRINT FULL NAME: Sarah Garrison

3. (b) If veteran, name war: ____

3. (c) Social Security No.: ____

4. Sex: Female

5. Color or race: Wh

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: William Garrison

6. (c) Age of husband or wife if alive: 83 years

7. Birth date of deceased: April (Month) 1 (Day) 1865 (Year)

8. AGE: Years 83 | Months 7 | Days 17 | If less than one day ____ hr. ____ min.

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

10. Usual occupation: Housewife

11. Industry or business: ____

FATHER
12. Name: Jeff Howell
13. Birthplace: Missouri (City, town, or county) ____ (State or foreign country)

MOTHER
14. Maiden name: Sarah Forrester
15. Birthplace: Missouri (City, town, or county) ____ (State or foreign country)

16. (a) Informant: Mrs. Clemma McCullah
(b) Address: Republic, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11/21/48 (Month) (Day) (Year)
(c) Place: burial or cremation: Osa, Missouri

18. (a) Signature of funeral director: [illegible]
(b) Address: Aurora, M.

19. (a) 11-21-48 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 18 year 1948 hour 6 minute 30 P.M.

21. I hereby certify that I attended the deceased from Dec — 1935 to Nov 18 1948 that I last saw her alive on November 18 1948 and that death occurred on the date and hour stated above.

Immediate cause of death: Complicating recently Fracture of left hip

Due to: hip suffered in August 1948

Due to: ____

Other conditions (Include pregnancy within 3 months of death): ____

Duration: ____

Major findings:
Of operations: 1864
Of autopsy: 18

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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)

While at work? ____ (e) Means of injury: ____

23. Signature: [illegible] (M. D. or other)

Address: Eunard, Mo. Date signed 11-19-48

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District ... Officer No. 6,
District File No. 1248-1348
Date Filed 12-8-48

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 Louis King

Licensed Embalmer No. 3529

P. O. Address Aurora, 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.

No. 2B
1—3-45
1 X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

37224-48

State File No. Dec

Registration District No. 175 Primary Registration District No. 3036 Registrar's No. 103

1. PLACE OF DEATH:

(b) County Lawrence

(b) City or town Aurora
(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)

In this community

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

3. (a) PRINT FULL NAME Sarah Gannon

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 M

6. (b) Name of husband or wife

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

7. Birth date of deceased April 1 (Month) (Day) (Year)

8. AGE: Years 83 Months 7 Days If less than one day hr. min.

9. Birthplace (City, town, or county) No (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day 8 year 1948 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h 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

(c) Where did injury occur? Aurora (City or town) Lawrence (County) Mo (State)

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

While at work? (e) Means of injury Fell

23. Signature A. P. Coppedge M.D. (M. D. or other)

Address Aurora, Mo. Date signed 12-22-48

SUPPLEMENTARY

S-37224