DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 29 1948

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

39335

State File No.

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 325

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

1. PLACE OF DEATH:

(a) County BOONE

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

(c) Name of hospital or institution: ELLIS FISCHEL STATE CANCER HOSPITAL (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 154 DAYS (Specify whether

In this community 154 days years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JASPER 49

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

(d) Street No. 0 (If rural, give location)

(e) Citizen of foreign country? No (~~Yes or~~ No) 1

If yes, name country

3. (a) PRINT FULL NAME MINNIE MYRTLE GARRETSON

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F 1

5. Color or race W

6. (a) Single, widowed, married, divorced M 1

6. (b) Name of husband ~~or wife~~ THERON GARRETSON

6. (c) Age of husband or wife if alive 81 years

7. Birth date of deceased MARCH (Month) 16 (Day) 1889 (Year)

8. AGE:

Years	Months	Days	If less than one day
59	9	3	hr. min.

9. Birthplace REEDS (City, town, or county) MISSOURI (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name PERRY McBRIDE 1
13. Birthplace (City, town, or county) ILLINOIS (State or foreign country)

MOTHER
14. Maiden name ELIZABETH ALUMBAUGH
15. Birthplace (City, town, or county) INDIANA (State or foreign country) 1

16. (a) Informant Hospital Records

(b) Address Columbia Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 12 (Month) 20 (Day) 48 (Year)

(c) Place: burial or cremation Carthage Mo

18. (a) Signature of funeral director Parker Funeral Service

(b) Address Columbia Mo.

19. (a) Dec 20 - 48 (Date received local registrar) (b) Mrs R. E. Palmer (Registrar's signature) 3

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 19 year 1948 hour 8 minute 00 P M.

21. I hereby certify that I attended the deceased from July 19, 1948, 19, to Dec. 19, 1948; that I last saw her alive on December 19, 1948; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hemorrhagic diathesis	3 mo
Due to: Subacute lymphatic leukemia	1 yr.
Due to	
Other conditions (Include pregnancy within 3 months of death)	

74A

Major findings:
Of operations

Of autopsy Confirms above

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 7

23. Signature R. E. Johnson (M. D. ~~or other~~)

Address Columbia Mo Date signed 12/20/48

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number DEC 28 1948
Date Filed

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 Tom McLaug

Licensed Embalmer No. 4067

P. O. Address Columbia, Me

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

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

2B
3-45
X43880

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STANDARD CERTIFICATE OF DEATH

State File No. Jan

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 325

1. PLACE OF DEATH:

(a) County Boone

(b) City or town Columbia
(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
In this community
years, months or days)

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 Minnie M. Gaunston

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 March (Month) 16 (Day) 1888 (Year)

8. AGE: Years 59 Months 9 Days 3 If less than one day hr. min.

9. Birthplace (City, town, or county) MO (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) 12-20-48 (Date received local registrar) (b) Mrs R E Palmer (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Dec Day 19
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)

(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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

39335