

FILED MAY 31 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18478**

BIRTH NO. _____		REG. DIST. NO. 378		PRIMARY REG. DIST. NO. 4552		Registrar's No. 15	
1. PLACE OF DEATH a. COUNTY WRIGHT				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY WRIGHT MO			
b. CITY OR TOWN MOUNTAIN GROVE		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN MOUNTAIN GROVE; MO		d. STREET ADDRESS (If rural, give location) EAST FIRST ST	
d. FULL NAME OF HOSPITAL OR INSTITUTION				3. NAME OF DECEASED a. (First) JOHN b. (Middle) FOSTER c. (Last) GARRISON			
4. DATE OF DEATH (Month) (Day) (Year) MAY 4 1949		5. SEX Male		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) DIVORCED	
8. DATE OF BIRTH DEC 9, 1870		9. AGE (In years last birthday) 78		10. MONTHS 4		11. HOURS 25	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BLACK SMITH		10b. KIND OF BUSINESS OR INDUSTRY BLACKSMITH		11. BIRTHPLACE (State or foreign country) WACKED CO MO		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME WILLIAM GARRISON		13b. MOTHER'S MAIDEN NAME OREGON BIVENS		14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME OWEN GARRISON			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) Cardiac failure		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac failure				ADDRESS MTN GROVE MO	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Not known				INTERVAL BETWEEN ONSET AND DEATH	
DUE TO (c)		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				7824	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 5:00 Am. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Thomas A. Mauldin Coronator				23b. ADDRESS Newwood, Mo		23c. DATE SIGNED 5/4/1949	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE MAY 6, 1949		24c. NAME OF CEMETERY OR CREMATORY LOVE STAR		24d. LOCATION (City, town, or county) (State) MOUNTAIN GROVE MO	
DATE REC'D BY LOCAL REG. 5-9-49		REGISTRAR'S SIGNATURE A.B. Ames		25. FUNERAL DIRECTOR'S SIGNATURE GRABLE - WINDLE		ADDRESS MTN GROVE MO	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Officer No. 6.
District File Number 5489-6158
Date Filed 5-26-49

Frank Grable

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Frank Grable

Licensed Embalmer No. 4140

P. O. Address mtn Grove, m

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.