

FILED AUG 30 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

25958  
State File No. \_\_\_\_\_

BIRTH NO. _____		REG. DIST. NO. <u>1</u>	PRIMARY REG. DIST. NO. <u>3000</u>	Registrar's No. <u>247</u>
1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____		
b. CITY OR TOWN <u>Kirksville</u> (If outside corporate limits, write RURAL and give township)	c. LENGTH OF STAY (in this place) <u>4</u>	c. CITY (If outside corporate limits, write RURAL and give township) <u>Sedelia</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Community Nursing Home #1</u>		d. STREET ADDRESS (If rural, give location) <u>1521 S. Vermont St 1</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>FRANK</u> b. (Middle) <u>S</u> c. (Last) <u>GARNER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 21 1949</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never married</u>	8. DATE OF BIRTH <u>June 15 1916</u>	9. AGE (In years last birthday) <u>33</u> 10. UNDER 1 YEAR Months _____ Days _____ 11. UNDER 18 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Truck driver</u>		11. BIRTHPLACE (State or foreign country) <u>Sedelia Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13a. FATHER'S NAME <u>Charles Garner</u>		
13b. MOTHER'S MAIDEN NAME <u>Berna B</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Supervisor Nursing Home Kirksville Mo</u> ADDRESS _____
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Anoxia</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Mucous plugs in bronchi</u> DUE TO (c) <u>Bronchial pneumonia</u>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>paralysis following brain surgery in 1940</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 min</u> <u>1 day</u> <u>3 days</u> <u>7/9/50</u>
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 <u>Aug 8</u> , 19 <u>49</u> , to <u>Aug 21</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>Aug 20</u> , 19 <u>49</u> , and that death occurred at <u>5:00</u> m., from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) <u>M. T. Sutenashu D.O.</u>		23b. ADDRESS <u>Kirksville, Mo</u>		23c. DATE SIGNED <u>8-21-49</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	24b. DATE <u>8-21-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Marshall</u>	24d. LOCATION (City, town, or county) (State) <u>Marshall Mo</u>	
DATE REC'D BY LOCAL REG. <u>8-21-49</u>	REGISTRAR'S SIGNATURE <u>Kate Lambert</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Rudolph Davis</u> ADDRESS <u>Kirksville Mo</u>		

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

RECEIVED AUG 29 1948  
District Health Officer No. 10  
District File Number 8-49-148  
Date Filed AUG 29 1948

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

*Clarence M. Bill*

Licensed Embalmer No. 4375

P. O. Address Kirkcull, 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.