

FILED NOV 14 1949

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. 34841

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

BIRTH NO. <u>124</u>		REG. DIST. NO. <u>316</u>		PRIMARY REG. DIST. NO. <u>3059</u>		Registrar's No. <u>389</u>		
1. PLACE OF DEATH a. COUNTY <u>ST. FRANCOIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. FRANCOIS</u>				
b. CITY OR TOWN <u>BONNE TERRE</u>		c. LENGTH OF STAY (in this place) <u>9 da.</u>		c. CITY OR TOWN <u>FARMINGTON</u>		94		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>BONNE TERRE HOSPITAL</u>				d. STREET ADDRESS (If rural, give location) <u>609 W. COLUMBIA</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>VICTORIA</u> b. (Middle) <u>CATHERINE</u> c. (Last) <u>GARNER</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>OCT. 31, 1949</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED <u>WIDOWED</u>		8. DATE OF BIRTH <u>NOV. 9 1863</u>		
9. AGE (in years last birthday) <u>85</u>		if UNDER 1 YEAR Months <u>11</u> Days <u>22</u>		if UNDER 11 HRS. Hours <u></u> Min. <u></u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>FERRYVILLE, MO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>JOSEPH HOFFMAN</u>			13b. MOTHER'S MAIDEN NAME <u>MARTHA WELKER</u>		14. NAME OF HUSBAND OR WIFE <u>EDWARD GARNER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT'S SIGNATURE OR NAME <u>RUTH GARNER</u> ADDRESS <u>CITY</u>				
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, asphyxia, etc.* It means the disease, injury, or complication which caused death.								
MEDICAL CERTIFICATION								
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Corynebacterium</u>		INTERVAL BETWEEN ONSET AND DEATH						
ANTECEDENT CAUSES		DUE TO (b) <u>Corynebacterium Anterivascularis</u>						
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c) <u>General Anterivascularis</u>						
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypertensive Cardiovascular</u>						
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Disease</u>				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)		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>10-22, 1949</u> to <u>10-31, 1949</u> that I last saw the deceased alive on <u>10-30, 1949</u> and that death occurred at <u>12:10 A.M.</u> , from the causes and on the date stated above.								
23a. SIGNATURE <u>F.R. Crowell M.D.</u> (Degree or title)				23b. ADDRESS <u>Farmington Mo.</u>		23c. DATE SIGNED <u>10-31-49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>NOV. 1, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>MASONIC CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>FARMINGTON MO</u>		
DATE REC'D BY LOCAL REG. <u>Nov. 2, 1949</u>		REGISTRAR'S SIGNATURE <u>Ethel Rudloff</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>C. Brozen</u> ADDRESS <u>City</u>				

11-7-49

District Health Officer No. 4

District File Number 1149-1472

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

Student Embalmer No.

working under my personal supervision.

Student Student Embalmer

Signed

C. Hozean

Licensed Embalmer No. 4084

P. O. Address Farmington 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.