

30235

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registrar's No. ....

FILED OCT 16 1950

|   |                            |  |   |   |   |  |                                       |  |                                    |  |  |
|---|----------------------------|--|---|---|---|--|---------------------------------------|--|------------------------------------|--|--|
| BIRTH NO. _____   |                            | REG. DIST. NO. <u>141</u>  |   | PRIMARY REG. DIST. NO. <u>3025</u>  |   | Registrar's No. <u>46</u>  |                                       |  |                                    |  |  |
| 1. PLACE OF DEATH   |                            |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).  |   |  |                                       |  |                                    |  |  |
| a. COUNTY<br><b>Howell</b>  |                            | a. STATE<br><b>Missouri</b>  |   | b. COUNTY<br><b>Howell</b>  |   | b. COUNTY (admission).   |                                       |  |                                    |  |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR<br>TOWN <b>West Plains</b>   |                            | c. LENGTH OF STAY (In this place)<br><b>20 years</b>                                     |   | c. CITY (If outside corporate limits, write RURAL and give township)<br>OR<br>TOWN <b>West Plains</b>   |   | <b>0421</b>  |                                       |  |                                    |  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Mask Rest Home</b>  |                            |  |   | d. STREET ADDRESS (If rural, give location)<br><b>W.</b>  |   |  |                                       |  |                                    |  |  |
| 3. NAME OF DECEASED (Type or Print)   |                            |  | 4. DATE OF DEATH                            |   |   | 5. SEX   |                                       |  |                                    |  |  |
| a. (First)<br><b>Anna</b>   | b. (Middle)<br><b>Jane</b> | c. (Last)<br><b>Garrett</b>  | (Month)<br><b>August</b>                    | (Day)<br><b>15</b>  | (Year)<br><b>1950</b>   | F  | W                                     |  |                                    |  |  |
| 6. COLOR OR RACE<br><b>W</b>  |                            | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>                 |   | 8. DATE OF BIRTH<br><b>May. 14, 1867</b>  |   | 9. AGE (In years last birthday)<br><b>83</b>                                 | IF UNDER 1 YEAR<br>Months<br><b>3</b> | IF UNDER 12 HRS.<br>Days<br><b>1</b>   | Hours<br><b>1</b>                  | Min.<br><b>0</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                            |  | 10b. KIND OF BUSINESS OR INDUSTRY           |   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Unknown</b>                  |                                       | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |                                    |  |  |
| 13a. FATHER'S NAME<br><b>Unknown</b>  |                            |  | 13b. MOTHER'S MAIDEN NAME<br><b>Unknown</b> |   |   | 14. NAME OF HUSBAND OR WIFE<br><b>Ben Garrett</b>                            |                                       |  |                                    |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>   |                            | 16. SOCIAL SECURITY NO.  |   | 17. INFORMANT'S SIGNATURE OR NAME   |   |  | ADDRESS                               |  |                                    |  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.                                 |                            |  |   | MEDICAL CERTIFICATION   |   |  |                                       | INTERVAL BETWEEN ONSET AND DEATH   |                                    |  |  |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*<br><b>Carcinoma of right side of face &amp; throat.</b>  |                            |  |   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____ |   |  |                                       | 191X   |                                    |  |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |                            |  |   | 19a. DATE OF OPERATION  |   |  |                                       | 19b. MAJOR FINDINGS OF OPERATION   |                                    | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input 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>Aug. 12</u> , 1950, to <u>Aug 15</u> , 1950, that I last saw the deceased alive on <u>Aug 12</u> , 1950, and that death occurred at <u>7:00 a. m.</u> , from the causes and on the date stated above. |                            |  |   |   |   |  |                                       |  |                                    |  |  |
| 23a. SIGNATURE<br><b>D. Richard A. Smith D. O.</b>  |                            |  |   |   |   | 23b. ADDRESS<br><b>West Plains, Mo.</b>                                      |                                       |  | 23c. DATE SIGNED<br><b>8-21-50</b> |  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>B</b>   |                            | 24b. DATE<br><b>8-17-50</b>  |   | 24c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn</b>   |   | 24d. LOCATION (City, town, or county) (State)<br><b>West Plains Missouri</b> |                                       |  |                                    |  |  |
| DATE REC'D BY LOCAL REG.<br><b>10-3-50</b>  |                            | REGISTRAR'S SIGNATURE<br><b>Beatrice Cook</b>  |   |   | 25. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robertson Funeral Home</b> |  |                                       | ADDRESS<br><b>West Plains, Mo.</b>   |                                    |  |  |

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300  
10-48461  
4

DIVISION OF HEALTH OF MO.  
District No. 5 - Springfield

RECEIVED OCT 9 1950  
Dist. File 1050-2078  
Date Filed 10-9-50

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.

Signed \_\_\_\_\_

*[Handwritten Signature]*  
Licensed Embalmer No. 45747

Signed \_\_\_\_\_  
Student Embalmer

P. O. Address \_\_\_\_\_

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.