

THE DIVISION OF HEALTH - MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB 1 1953

State File No. 4434

BIRTH NO. _____ REG. DIST. NO. 324 PRIMARY REG. DIST. NO. 3072 Registrar's No. 21

1. PLACE OF DEATH a. COUNTY Saline		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Saline	
b. CITY (If outside corporate limits, write RURAL and give town) Marshall	c. LENGTH OF STAY (in this place) 3 Wks.	c. CITY (If outside corporate limits, write RURAL and give township) Hardeman Rural Arrow Rock Twp	
d. FULL NAME OF HOSPITAL OR INSTITUTION Fitzgibbon Mem. Hospital		d. STREET ADDRESS (If rural, give location) Hardeman 0970	

3. NAME OF DECEASED (Type or Print)	a. (First) LEWIS	b. (Middle) WILLIAM	c. (Last) GARRETT	4. DATE OF DEATH (Month) (Day) (Year) Jan. 27, 1953
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 13, 1873	9. AGE (In years last birthday) 79 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tenant Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Iziah Garrett	13b. MOTHER'S MAIDEN NAME Sallie Brown	14. NAME OF HUSBAND OR WIFE Mrs. L.W. Garrett
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. L.W. Garrett Napton, Mo.

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 6 hrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving DUE TO (b) _____ rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 1561			

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)	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 **1-4**, 19**53**, to **1/27**, 19**53** that I last saw the deceased alive on **1-27**, 19**53** and that death occurred at **7:55 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) R. W. ... M.D.	23b. ADDRESS Marshall, Mo.	23c. DATE SIGNED 1/27/53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Jan. 29, 1953	24c. NAME OF CEMETERY OR CREMATORY Arrow Rock Cem.	24d. LOCATION (City, town, or county) (State) Arrow Rock, Mo.
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DATE REC'D BY LOCAL REG. 1-27-1953	REGISTRAR'S SIGNATURE Sidney J. Gray 385	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Fanny Hershberger Marshall, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

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 Joseph R. Marshall

Licensed Embalmer No. 4571

P. O. Address W. Marshall

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.