

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15711**
Registrar's No. **4012**

FILED MAY 14 1953

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE Missouri. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis ²²⁰⁹	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2829a North 20th Street		e. STREET ADDRESS (If rural, give location) 2829a North 20th Street.	
3. NAME OF DECEASED (Type or Print) a. (First) Malinda		b. (Middle) Caroline	
		c. (Last) Garrison	
4. DATE OF DEATH (Month) (Day) (Year) Apr. 17, 1953			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 29, 1880
9. AGE (In years last birthday) 73		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) Missouri.		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME James Hasty		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Wm. H. Garrison,			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Wm. H. Garrison, 2829a North 20th St.		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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic myocarditis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) With hypertension DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS 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? 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) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 443X			
22. I hereby certify that I attended the deceased from April 7, 1953 , to April 17, 1953 , that I last saw the deceased alive on April 17, 1953 , and that death occurred at 5:30 a.m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) John C. Creane MD		23b. ADDRESS 2504 N. 14th St	
23c. DATE SIGNED 4-17-53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Apr. 20, 1953	
24c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.	
DATE REC'D BY LOCAL REG. APR 17 1953		REGISTRAR'S SIGNATURE J. Carl Smith MD	
25. FUNERAL DIRECTOR'S SIGNATURE Leidner Und. Co.		ADDRESS 2223 St. Louis Av.	

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.....
Signature of Student Embalmer

Signed *J. W. Bembley*.....

Licensed Embalmer No. *365*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.