No. 300
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED JUL 19 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 45714

BIRTH NO. _____ REG. DIST. NO. 141 PRIMARY REG. DIST. NO. 3025 Registrar's No. 2

1. PLACE OF DEATH
a. COUNTY: Howell
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): West Plains,
c. LENGTH OF STAY (In this place): ?
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ~~Mask Rest Home~~

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Howell
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): West Plains,
d. STREET ADDRESS (If rural, give location): W. Broadway 0461 D

3. NAME OF DECEASED (Type or Print)
a. (First): BEN
b. (Middle): H.
c. (Last): GARRETT

4. DATE OF DEATH (Month) (Day) (Year): 9-14-53

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): W
8. DATE OF BIRTH: 5-14-1867
9. AGE (In years last birthday): 9 — 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): retired farmer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): UNK
12. CITIZEN OF WHAT COUNTRY?: U S A
13a. FATHER'S NAME: UNK
13b. MOTHER'S MAIDEN NAME: UNK
14. NAME OF HUSBAND OR WIFE: X
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): X
(If yes, give war or dates of service): X
16. SOCIAL SECURITY NO.: X
17. INFORMANT'S SIGNATURE OR NAME / ADDRESS: X

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

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: 4222
20. AUTOPSY? YES ☐ NO ☐

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 9-13-1953, *to* 9-14-, 1953 *that I last saw the deceased alive on* 9-14-, 1953, *and that death occurred at* 2.45 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Dr. Richard A. Smith D.O.
23b. ADDRESS: 913 W. Main West Plains Mo.
23c. DATE SIGNED: 7-5-54

24a. BURIAL, CREMATION, REMOVAL (Specify): B
24b. DATE: 9-16-53
24c. NAME OF CEMETERY OR CREMATORY: OAK LAWN CEMETERY
24d. LOCATION (City, town, or county) (State): WEST PLAINS, MO.

DATE REC'D BY LOCAL REG.: 7-15-54
REGISTRAR'S SIGNATURE: Beatrice Cook
379
25. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: ROBERTSON'S, WEST PLAINS, MO

(Licensed Embalmer's Statement on Reverse Side)

JUL 20 1954

JUL 21 1954

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 L. S. Roberts

Licensed Embalmer No. [illegible]

P. O. Address [illegible]

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.