

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED MAY 26 1954

No. 300

10-48

BIRTH NO. _____		REG. DIST. NO. <u>156</u>		PRIMARY REG. DIST. NO. <u>2001</u>		Registrar's No. <u>222</u>			
1. PLACE OF DEATH a. COUNTY <b>JASPER</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY <b>JASPER</b>					
b. CITY (If outside corporate limits, write RURAL and give town) <b>JOPLIN</b>		c. LENGTH OF STAY (In this place) <b>4 WEEKS</b>		c. CITY OR TOWN <b>JOPLIN</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. JOHN'S HOSPITAL</b>				e. STREET ADDRESS (If rural, give location) <b>1304 KENTUCKY AVE.</b> <u>0490</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <b>ALBERT N. GARRISON.</b>			b. (Middle)		c. (Last) <b>GARRISON</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>MAY 14, 1954</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>SEPT. 12, 1871</b>		9. AGE (In years last birthday) <b>82</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED-FARMER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>BETHANY, MO.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13a. FATHER'S NAME <b>JAMES GARRISON</b>			13b. MOTHER'S MAIDEN NAME <b>LYDIA JOHNSON</b>		14. NAME OF HUSBAND OR WIFE <b>NELLIE GARRISON</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>UNK</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT'S SIGNATURE OR NAME <b>CLARENCE GARRISON, RT. 2, JOPLIN, MO.</b>				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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Toxemia</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b>	
		ANCECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Dropsy both legs</b> <b>4 weeks</b>							
		DUE TO (c) <b>thrombosis abdominal aorta</b> <b>4 weeks</b>							
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Senile - recent basal structures, nothing</b>							
19a. DATE OF OPERATION <b>5-28-54</b>		19b. MAJOR FINDINGS OF OPERATION <b>paralytic sterc from sigmoidally appendicitis</b> <b>551X</b>						20. AUTOPSY? YES <input checked="" 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) (M.)		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>3-27</u> , 19 <u>54</u> , to <u>5-14</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>5-14</u> , 19 <u>54</u> , and that death occurred at <u>4 P.</u> m., from the causes and on the date stated above.									
23a. SIGNATURE <b>Robert T. Smith, MD.</b> (Degree or title)				23b. ADDRESS <b>Union Bldg Joplin, Mo.</b>			23c. DATE SIGNED <b>5-17-54</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>5-17-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>FAIRVIEW CEMETERY</b>		24d. LOCATION (City, town, or county) (State) <b>JOPLIN, MISSOURI</b>				
DATE REC'D BY LOCAL REG. <b>5-19-54</b>		REGISTRAR'S SIGNATURE <b>W. S. James</b> <u>138</u> <b>by Robert Campbell</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>STEVE PARKER MORTUARY, JOPLIN, MO.</b>				ADDRESS	

(Licensed Embalmer's Statement on Reverse Side)

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

MAY 26 1954

RECEIVED MAY 24 1954  
Jasper County Health Office  
County File Number 54-5-393  
Date Filed MAY 24 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.....  
\* Signature of Student Embalmer

Signed *F. M. Jones*.....

Licensed Embalmer No. 2311

P. O. Address *Joplin*

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.