

FILED AUG 9 - 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

23909

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 274 PRIMARY REG. DIST. NO. 3052 Registrar's No. 294

1. PLACE OF DEATH a. COUNTY <b>PETTIS</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY <b>PETTIS</b>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>SEDALIA</b>		c. LENGTH OF STAY (in this place) <b>2 Wks</b>		c. CITY OR TOWN <b>SEDALIA</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>BOTHWELL HOSPITAL</b>				e. STREET ADDRESS (If rural, give location) <b>417 E. 14th St.</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>MABEL</b>		b. (Middle) <b>MAE</b>		c. (Last) <b>GARST</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>July 30, 1954</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>Sept 27, 1889</b>	
9. AGE (In years last birthday) <b>64</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Mins. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Putmanville, Ind.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Hebron Ballard</b>			13b. MOTHER'S MAIDEN NAME <b>Mary Brewington</b>			14. NAME OF HUSBAND OR WIFE <b>E. G. Garst</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>E. G. Garst, Sedalia, Mo.</b>			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pulmonary embolism</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Fracture of rt hip</b> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>E 90-35 44</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>10 days</b>	
19a. DATE OF OPERATION <b>7/21/54</b>		19b. MAJOR FINDINGS OF OPERATION <b>Pinning of fracture of neck of rt femur</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>Accident</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) <b>12 (STATE)</b>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>July 17, 1954 11 AM</b>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>Fell in street.</b>			
22. I hereby certify that I attended the deceased from <b>July 17, 1954</b> , to <b>July 30, 1954</b> , that I last saw the deceased alive on <b>July 30, 1954</b> , and that death occurred at <b>1 A</b> m., from the causes and on the date stated above.							
23a. SIGNATURE (In case or title) <b>John E. Remy M.D.</b>				23b. ADDRESS <b>111 West 4th Sedalia Mo</b>		23c. DATE SIGNED <b>7/30/54</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>8/2/54</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Crown Hill Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Sedalia, Mo.</b>	
DATE REC'D BY LOCAL REG. <b>7/31/54</b>		REGISTRAR'S SIGNATURE <b>Lorna Coontz Dept</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Thorne Coontz Sedalia, Mo.</b>			

Licensed Embalmer's Statement on Reverse Side)

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

8-2-54

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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. *Shane Ewing*.....

Licensed Embalmer No. *28*.....

P. O. Address *Salina*.....

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.