

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **29913**

FILED OCT 7 - 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **146** PRIMARY REG. DIST. NO. **5568** Registrar's No. **371**

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Laclede</b>	
b. CITY OR TOWN <b>INDEPENDENCE</b>		c. CITY OR TOWN <b>LEBANON</b>	
c. LENGTH OF STAY (in this place) <b>1 MONTH</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>126 SOUTH CLAREMONT</b>		e. STREET ADDRESS (If rural, give location) <b>053 21</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>ANNA</b>	b. (Middle) <b>BELLE</b>	c. (Last) <b>GARR</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Sept 27, 1955</b>
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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>MARCH 9, 1884</b>	9. AGE (In years last birthday) <b>71</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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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>AT HOME</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>LACLEDE CO., MO</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>FRANCIS M. ROBERTS</b>	13b. MOTHER'S MAIDEN NAME <b>SAMANTHA SOUTHARD</b>	14. NAME OF HUSBAND OR WIFE <b>ANDY M. GARR</b>
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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 <b>MR RALPH GARR</b>	ADDRESS <b>LEBANON, MO.</b>
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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		INTERVAL BETWEEN ONSET AND DEATH <b>8 yrs</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of Metastases</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>(Primary in Cervix)</b> <b>8 yrs ago</b> DUE TO (c) <b>171X</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Gen. Cachexia</b>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Sept 10, 1955**, to **Sept 27, 1955**, that I last saw the deceased alive on **Sept 25, 1955**, and that death occurred at **5:45 P. M.**, from the causes and on the date stated above.

23a. SIGNATURE <b>R. Blalock M.D.</b> (Degree or title)	23b. ADDRESS <b>1210 Ash Independence, Mo</b>	23c. DATE SIGNED <b>9-28-55</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>SEP. 28, 1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>HARTVILLE</b>	24d. LOCATION (City, town, or county) (State) <b>MISSOURI</b>
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DATE REC'D BY LOCAL REG. <b>9-28-55</b>	REGISTRAR'S SIGNATURE <b>[Signature]</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>D. W. NEWCOMERS SONS</b>	ADDRESS <b>KANSAS CITY, MO.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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..... *Rebbie Kessel* .....

Licensed Embalmer No. *469*.....

P. O. Address *K.C.M.*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.