

No. 300
10-48

FILED FEB 4 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **1066**

BIRTH NO. _____ REG. DIST. NO. **133** PRIMARY REG. DIST. NO. **3022** Registrar's No. **33**

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

I. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)	
a. COUNTY Harrison	b. CITY (If outside corporate limits, write RURAL and give town) Bethany	c. LENGTH OF STAY (In this place) 0	a. STATE Missouri
d. FULL NAME OF HOSPITAL OR INSTITUTION Holl Hospital D.O.A.	c. CITY (If outside corporate limits, write RURAL and give township) Rural Bethany Twp.		b. COUNTY Harrison
3. NAME OF DECEASED		d. STREET ADDRESS (If rural, give location)	
a. (First) Albert	b. (Middle) Harold	c. (Last) Garton	

4. DATE OF DEATH (Month) (Day) (Year) 1-28-57	5. SEX M	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 2-26-1903	9. AGE (In years last birthday) 53	IF UNDER 1 YEAR Months 10 Days 27	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Harrison County Mo		12. CITIZEN OF WHAT COUNTRY? U-S	

13a. FATHER'S NAME George W. Garton	13b. MOTHER'S MAIDEN NAME Amanda Garton	14. NAME OF HUSBAND OR WIFE Ruby Garton
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Ruth Francis Bethany Mo

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		INTERVAL BETWEEN ONSET AND DEATH ONE HOUR YEARS: _____
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ACUTE CORONARY THROMBOSIS		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE		
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 4000	20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> 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) _____	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 _____, 19____, to _____, 19____, that I last saw the deceased alive on **D.O.A.**, 19____, and that death occurred at **7 P.** m., from the causes and on the date stated above.

23a. SIGNATURE Albert Dubbe M.D.	23b. ADDRESS Bethany, Mo.	23c. DATE SIGNED Jan. 29, 1957
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1-28-57	24c. NAME OF CEMETERY OR CREMATORY Mission
24d. LOCATION (City, town, or county) (State) Bethany Mo	25. FUNERAL DIRECTOR'S SIGNATURE McNair ADDRESS Bethany, Mo	

DATE REC'D BY LOCAL REG. 1-29-57	REGISTRAR'S SIGNATURE Zola Burris	25. FUNERAL DIRECTOR'S SIGNATURE McNair ADDRESS Bethany, Mo
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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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....

M. J. [Signature]

Signed.....
Student Embalmer

Licensed Embalmer No. 3899

P. O. Address Bethany Mo.

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