

FILED SEP 9 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **28006**
Registration District No. **128** Primary Registration District No. **2000** Registrar's No. **851**

800
-57

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		c. CITY OR TOWN Springfield	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Hospital		d. STREET ADDRESS (If outside, give location) 1321 W. Chase	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Length of stay in 1b 11 days		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) VICKIE LEE GARRETT			4. DATE OF DEATH Month August Day 29 Year 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 13, 1957		9. AGE (In years last birthday) 11
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY Infant		11. BIRTHPLACE (City and state or country) Springfield, Missouri	
13a. FATHER'S NAME Troy C. Garrett			13b. MOTHER'S MAIDEN NAME Wanda Lee Hart		14. NAME OF HUSBAND OR WIFE ---
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 Troy C. Garrett, Springfield, Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congenital Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 11 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. Transposition of Great Vessels		
Patent Ductus arteriosus		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 7541		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION Springfield	COUNTY Greene	STATE Missouri
21. I attended the deceased from 8-18-57 to 8-29-57 and last saw her alive on 8-29-57 Death occurred at 8-29-57 11:20 AM on the date stated above; and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree or title) E. J. Schwartz M.D.	22b. ADDRESS 609 Cherry, Springfield Mo	22c. DATE SIGNED 8-30-57
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Aug. 30, 1957	23c. NAME OF CEMETERY OR CREMATORY White Chapel Cemetery	23d. LOCATION (City, town, or county) (State) Springfield, Missouri
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24. FUNERAL DIRECTOR Jewell C. Windle ADDRESS Springfield, Mo.	25. DATE RECD. BY LOCAL REG. 8-29-3-57	26. REGISTRAR'S SIGNATURE Edith Williamson
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Robert E. Nobleman*

Licensed Embalmer No. *4916*
P. O. Address *Springfield*

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.