Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-035672
STATE FILE NUMBER

FILED OCT 20 1958

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 225

1. PLACE OF DEATH
a. COUNTY CALLAWAY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN FULTON — Inside Limits Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. HOSPITAL #1 — Length of stay in Ib 2yr 9mo

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY BOONE
c. CITY OR TOWN COLUMBIA — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 0103 118 ALDEAH STREET — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First JASON Middle Last GARRETT
4. DATE OF DEATH Month Oct. Day 11 Year 1958
5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH May 28, 1892
9. AGE (In years on last birthday) 66 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JEWELER
10b. KIND OF BUSINESS OR INDUSTRY WATCHMAKER
11. BIRTHPLACE (City and state or country) KANSAS
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME ALLEN GARRETT
13b. MOTHER'S MAIDEN NAME ELIZABETH COOK
14. NAME OF HUSBAND OR WIFE MRS. JASON GARRETT
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES WORLD WAR # 1 (Give dates of service)
16. SOCIAL SECURITY NO. 492-36-9061
17. INFORMANT STATE HOSPITAL # 1 Address Fulton, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PNEUMONIA
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 493X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
CHRONIC BRAIN SYNDROME
19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ] 0

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
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 WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. X attended the deceased from 1/18/1956 to OCT. 11 58 and last saw her/him alive on OCT. 11 58
St. Hosp.
Death occurred at 3:00 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE R.C. Robertson (Degree or title) M.D. 0
22b. ADDRESS Fulton, Mo
22c. DATE SIGNED 10/11/58

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE Oct 14, 1958
23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cem.
23d. LOCATION (City, town, or county) Columbia (State) Mo

24. FUNERAL DIRECTOR Parker Funeral Svc ADDRESS Columbia Mo
25. DATE RECD. BY LOCAL REG. Oct 11 1958
26. REGISTRAR'S SIGNATURE Maretta Lawrence

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

OCT 22 1958

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 Chas L Zarung

Licensed Embalmer No. 4132

P. O. Address Columbia

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.