

FEDERAL BUREAU OF INVESTIGATION
 U.S. DEPARTMENT OF JUSTICE
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59-035175

FILED VS OCT 19 1959

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 487

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>BOONE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>DALLAS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>	Length of stay in 1b <u>41 Days</u>	c. CITY OR TOWN <u>Buffalo</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Ellis Fischel State Cancer Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>116 Poplar St.</u>

3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY DENNIE GARRISON</u>			4. DATE OF DEATH Month Day Year <u>Oct. 12 1959</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-22-85</u>	9. AGE (last birthday) <u>74</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (City and state or country) <u>KNOX Co. Ill.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>W.O. WELLS</u>		13b. MOTHER'S MAIDEN NAME <u>MARY NODDEN</u>		14. NAME OF HUSBAND OR WIFE <u>JONCE GARRISON</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>112 M.</u>	17. INFORMANT Address <u>Hospital Records Cancer Hospital</u>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC DECOMPENSATION - SECONDARY TO</u>		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE, CORONARY TYPE</u> <u>BILATERAL PULMONARY EDEMA -</u>		
DUE TO (c) <u>BILATERAL BRONCHOPNEUMONIA -</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>UNDIFFERENTIATED CARCINOMA</u> <u>EXTENSIVE OF PELVIS WITH INVASION OF CERVIX, VAGINA, RECTUM AND</u> <u>PARAMETRIA - WITH LOW INTESTINAL OBSTRUCTION - AND HYDRONEPHROSIS</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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. <u>1:30 p.m.</u>	20d. INJURY OCCURRED WHILE AT WORK <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.) <u>—</u>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>—</u>

21. I attended the deceased from 8-31-59 to 10-12-59 and last saw her/him alive on 10-12-59.
 Death occurred at 4 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>F Gary Brings, MD</u>	22b. ADDRESS <u>Columbia, Mo.</u>	22c. DATE SIGNED <u>10-12-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>10/14/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hope Well Cem. Dallas Co. Mo.</u>	23d. LOCATION (City, town, or county) (State) <u>—</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Montgomery Funeral Home Buffalo, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Oct 14, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. R. E. Palmer</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Boyle Montgomery

Licensed Embalmer No. 359

P. O. Address Buffalo

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.