

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 13 1960

60-002456

Registration District No. 195 Primary Registration District No. _____ Registrar's No. 3-60 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>McDonald</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>McDonald</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Prarie Twtnshp.</u>		Length of stay in lb <u>All of Life</u>		c. CITY OR TOWN <u>Southwest City</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>At Home</u>				d. STREET ADDRESS (If outside, give location) <u>Route 1</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bernice</u> First <u>A.</u> Middle <u>GARVIN</u> Last				4. DATE OF DEATH <u>Jan. 5, 1960</u> Month <u>Jan.</u> Day <u>5</u> Year <u>1960</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>10/22/84</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>14</u>	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>At Home</u>		11. BIRTHPLACE (City and state or country) <u>Lawrence Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>John Hoagland</u>			13b. MOTHER'S MAIDEN NAME <u>(Unknown)</u>			14. NAME OF HUSBAND OR WIFE <u>M. E. Garvin</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> <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>John Stewart Anderson, Missouri</u> Address _____			
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>Coronary Occlusion</u> <u>Rheumatic Heart Disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
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. Month, Day, Year _____	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.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <u>Feb 1956</u> to <u>Jan 1960</u> and last saw her <u>alive</u> on <u>1/5/60</u> Death occurred at <u>11:45 P.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u>				22b. ADDRESS <u>Noel, Mo</u>		22c. DATE SIGNED <u>1/9/60</u> (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1/8/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Peace Valley Cemetery</u>		23d. LOCATION (City, town, or county) <u>Anderson, Missouri.</u>		
24. FUNERAL DIRECTOR <u>Robert C. Roller Anderson, Missouri.</u> ADDRESS _____				25. DATE RECD. BY LOCAL REG. <u>1-8-1960</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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 Robert C. Roller

Licensed Embalmer No. 5062

P. O. Address Anderson,

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.