

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-009432

FILED VS FEB 29 1960 324

Registration District No. 3072 Primary Registration District No. 40 Registrar's No. 40

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Saline</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marshall</u>		Length of stay in 1b <u>17 hr 46 min</u>		c. CITY OR TOWN <u>Marshall</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Fiftygibbon Hosp</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4 mi E. Marshall Mo</u>			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>"INFANT"</u> Middle <u>GARRETT</u> Last <u>GARRETT</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>25</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>2-25-1960</u>	9. AGE (last birthday) IF UNDER 1 YEAR Months <u>17</u> Days <u>46</u>		IF UNDER 24 HR Hours <u>17</u> Min. <u>46</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (City and state or country) <u>Marshall Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Frank Enlo Garrett</u>			13b. MOTHER'S MAIDEN NAME <u>Marjorie Bennett</u>		14. NAME OF HUSBAND OR WIFE <u>---</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>none</u>		17. INFORMANT <u>Frank Enlo Garrett</u> Address <u>Marshall Mo R 4</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>Anoxia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hr.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Skylaw Man brace because</u>						<u>24 hr.</u>	
DUE TO (c) <u>---</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the principal disease condition given in PART I (a) <u>Crematorium Building @ Section 2225 to Marjorie Reading</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	
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 <u>8:00 P</u> Month, Day, Year <u>Feb 25</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.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>8:00 P</u> to <u>Feb 25</u> and last saw <u>her</u> live on <u>Feb 25</u> Death occurred at <u>8:00 P</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Dr. Kenneth C. ... M.D.</u>				22b. ADDRESS <u>Marshall Mo</u>		22c. DATE SIGNED <u>2-25-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2-26-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>High Hill Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Saline County Mo.</u>			
24. FUNERAL DIRECTOR <u>Harry Hershberger</u> ADDRESS <u>Marshall Mo</u>			25. DATE RECD. BY LOCAL REG. <u>2-26-60</u>		26. REGISTRAR'S SIGNATURE <u>Carl G. Reed</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 ^{not}
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Harry Hershberger

Licensed Embalmer No. 4357

P. O. Address Marshall

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.