IRI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-60-009646
STATE FILE NUMBER

FILED VS MAR 1 1960 360

Registration District No. _____ Primary Registration District No. 6225 Registrar's No. 35

NDED

1. PLACE OF DEATH
a. COUNTY: Washington Township
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Nevada — Length of stay in 1b: 9 yrs. 8 mos.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: State Hospital #3 — Inside Limits: Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: Wright
c. CITY OR TOWN: Mountain Grove — Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: J. Middle: O. Last: Garrison
4. DATE OF DEATH: Month: Feb. Day: 13 Year: 1960
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 1-16-1883
9. AGE (last birthday): 76 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HR: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Odd jobs
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): Missouri
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: William Garrison
13b. MOTHER'S MAIDEN NAME: Oregon Bevins
14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unknown (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Records — Address: State Hospital #3, Nevada, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Generalized Arteriosclerosis
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): Psychosis
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
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. I attended the deceased from March 1, 1956, to Feb. 13, 1960 and last saw him alive on Feb. 13, 1960
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: W. C. Bradley M.D. (Degree or Title)
22b. ADDRESS: State Hospital #3, Nevada, Mo.
22c. DATE SIGNED: 2-13-60

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 2-13-1960
23c. NAME OF CEMETERY OR CREMATORY: State Anatomical Board
23d. LOCATION (City or Town, State): Dr. Mildred Trotter, 4580 Scott Ave., St. Louis, 10, Mo

24. FUNERAL DIRECTOR: Ferry Funeral Home-Nevada, Missouri.
ADDRESS
25. DATE RECD. BY LOCAL REG.: Feb 24-1960
26. REGISTRAR'S SIGNATURE: Anna E Ferry

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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 b

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

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