

**FEDERAL BUREAU OF INVESTIGATION**  
**FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS. APR 5 1960 82

60-010370

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. 3017 Registrar's No. 65

1. PLACE OF DEATH a. COUNTY <u>Cooper</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Morgan</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Boonville</u>		Length of stay in 1b <u>6 weeks</u>	c. CITY OR TOWN <u>Versailles</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>St. Joseph Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>William</u> Last <u>Garrison</u>			4. DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>12-4-1903</u>	9. AGE (last birthday) <u>56</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Motors</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Camden Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John W. Garrison</u>		13b. MOTHER'S MAIDEN NAME <u>Lillie D. Hobdon</u>		14. NAME OF HUSBAND OR WIFE <u>Divorced</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>495-09-7723</u>	17. INFORMANT Address <u>Donald Garrison Kansas City, Mo.</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>Cerebral vascular accident</u>					INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertensive cardiovascular renal disease</u>					<u>10 years</u>
DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Congestive Heart Failure</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 _____ 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>5-16-55</u> to <u>3-31-60</u> and last saw <sup>him</sup> alive on <u>3-30-60</u> Death occurred at <u>7:55</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>William A. Alsh MP</u> (Degree or title)			22b. ADDRESS <u>329 Main Street Boonville, Mo.</u>		22c. DATE SIGNED <u>4-1-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2 Apr. 60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Versailles Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Versailles, Mo.</u>	
24. FUNERAL DIRECTOR <u>Kidwell Funeral Home Versailles, Mo.</u> ADDRESS _____		25. DATE RECD. BY LOCAL REG. <u>4/1/60</u>	26. REGISTRAR'S SIGNATURE <u>D. Hooper</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

APR 6 1960

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Raymond C. Foster

Licensed Embalmer No. 4626

P. O. Address Wesley

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.