

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. OCT 17 1960 128

-60-034410

Registration District No. 2000 Primary Registration District No. 2000 Registrar's No. 1025

STATE FILE NUMBER

|   |   |   |  |  |  |   |   |
|---|---|---|--|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Green</b>   |   |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo</b> b. COUNTY <b>Christian</b> |  |   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Springfield Mo</b>  |   | Length of stay in 1b<br><b>I 1/2 Hrs</b>  |  | c. CITY OR TOWN <b>Highlandville, Mo</b>   |  | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |   |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Hospital Springfield Baptist</b>   |   |   |  | d. STREET ADDRESS (If outside, give location)<br><b>N, Galloway Twp</b>  |  | Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Elwyn</b> Middle <b>E</b> Last <b>Garner</b>  |   |   |  | 4. DATE OF DEATH<br>Month <b>Oct</b> Day <b>8</b> Year <b>1960</b>   |  |   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>6/15/1913</b>   | 9. AGE (last birthday)<br><b>47</b>  | IF UNDER 1 YEAR<br>Months Days  | IF UNDER 24 HR<br>Hours Min.                |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farmer</b>  |   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Funk, Nebraska</b> |  | 11. BIRTHPLACE (City and state or country)<br><b>U S A</b>   |   | 12. CITIZEN OF WHAT COUNTRY<br><b>U S A</b> |
| 13a. FATHER'S NAME<br><b>Ray E Garner</b>   |   |   | 13b. MOTHER'S MAIDEN NAME<br><b>Adah E Nichols</b>         |  | 14. NAME OF HUSBAND OR WIFE<br><b>Vinnie Garner</b>  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>Yes 2nd 2nd, W, W</b>  |   |   | 16. SOCIAL SECURITY NO.<br><b>489-24-8223</b>              | 17. INFORMANT Address<br><b>Mrs Vinnie Garner, Highlandville, Mo</b>   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Thrombosis, coronary, extensive</b><br>DUE TO (b) <b>cardiac</b><br>DUE TO (c)<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |   |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hrs.</b>                                     |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Hypertension, severe</b>  |   |   |  |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input 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<br>Hour Month, Day, Year<br>a.m. p.m.   |   |   |  |  |  |   |   |
| 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 <b>Oct 8/60</b> to <b>8 Oct/60</b> and last saw <sup>her</sup> him alive on <b>8 Oct/60</b><br>Death occurred at <b>10/8/60 11:30 A M</b> on the date stated above, and to the best of my knowledge, from the causes stated.   |   |   |  |  |  |   |   |
| 22a. SIGNATURE (Degree or title)<br><b>[Signature] M.D.</b>   |   |   |  | 22b. ADDRESS<br><b>Ozark, Mo</b>   |  | 22c. DATE SIGNED<br><b>10 Oct/60</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE<br><b>10/10/60</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Selmore Cemetry</b>  |  | 23d. LOCATION (City, town, or county)<br><b>Christian Co</b>   |  | (State)<br><b>Mo</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>F. B. Chaffin</b>  |   |   | ADDRESS<br><b>Ozark, Mo.</b>                               | 25. DATE RECD. BY LOCAL REG.<br><b>10-13-60</b>  | 26. REGISTRAR'S SIGNATURE<br><b>Effie S. Melton</b>  |   |   |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

OCT 18 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

*T. R. Chaffin*

Licensed Embalmer No. 2192

P. O. Address Ozark

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.