

FEDERAL BUREAU OF INVESTIGATION
 U.S. DEPARTMENT OF JUSTICE
 NATIONAL CENTER FOR HEALTH STATISTICS
 NATIONAL BUREAU OF VITAL STATISTICS
 NATIONAL CENTER FOR HUMAN GENEALOGY

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034411

FILED VS OCT 10 1960

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 993

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Christian</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield, Mo</u>		Length of stay in 1b <u>II</u> Days	c. CITY OR TOWN <u>Ozark, Mo</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>Springfield Baptist Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>City</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Mattie</u> Middle <u>Jane</u> Last <u>Garrison</u>			4. DATE OF DEATH Month <u>Sept</u> Day <u>28</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 type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2/21/1880</u>	9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Kentucky State</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>
13a. FATHER'S NAME <u>George W Dobbs</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah J Campbell</u>		14. NAME OF HUSBAND OR WIFE	
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 Address <u>Mrs Lena Farthing, Sparta, Mo, Rt, I</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>Cerebrovascular accident - thrombotic spontaneous</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>arteriosclerosis</u>	<u>yes</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)	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
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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</u> a.m. / p.m. Month, Day, Year <u>20 Sept / 60</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION <u>Ozark, Mo</u>		COUNTY <u>Christian</u> STATE <u>Mo</u>

21. I attended the deceased from 20 Sept / 60 to 28 Sept / 60 and last saw her alive on 28 Sept / 60
 Death occurred at 9/20/60-8 P M 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>Ozark, Mo</u>	22c. DATE SIGNED <u>30 Sept / 60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10/1/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Linden</u>
23d. LOCATION (City, town, or county) <u>Christian Co, Mo</u>		(State)

24. FUNERAL DIRECTOR <u>F. B. Chaffin</u>	ADDRESS <u>Ozark, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>10-3-60</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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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 _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed T. B. Chaffin

Licensed Embalmer No. 2192

P. O. Address Ozark, Mo.

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.