

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

ED VS NOV 28 1960

=60-044850

Registration District No. 340 Primary Registration District No. 3075 Registrar's No. 99

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Stoddard</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Stoddard</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Dexter</u>		Length of stay in 1b	c. CITY OR TOWN <u>Dexter</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>Residence</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>338 North Poplar</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Grace Marie Keating Garland</u>	4. DATE OF DEATH Month Day Year <u>Nov. 6, 1960</u>
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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>12-16-1919</u>	9. AGE (last birthday) <u>40</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>20</u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Bloomfield, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
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13a. FATHER'S NAME <u>R. A. Keating</u>	13b. MOTHER'S MAIDEN NAME <u>Katherine Meinz</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
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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>R. A. Keating, Dexter, Mo.</u>	Address <u>f</u>
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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>Coronary Insufficiency</u> DUE TO (b) <u>Cardiac asthma + bronchial asthma</u> DUE TO (c) <u>T.R. Malignant</u>		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)		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.)
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20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> 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 <u>Bloomfield, Missouri</u>	COUNTY <u>Stoddard</u>	STATE <u>Missouri</u>
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21. I attended the deceased from _____ to _____ and last saw her/him alive on _____.
Death occurred at 7:00 A. M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Dr. H. Chastam M.D.</u> (Degree or title)	22b. ADDRESS <u>199 Walnut - Dexter, Mo</u>	22c. DATE SIGNED <u>11-9-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-8-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Walker</u>	23d. LOCATION (City, town, or county) (State) <u>Bloomfield, Missouri</u>
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24. FUNERAL DIRECTOR <u>Strickland-Rainey</u>	ADDRESS <u>Dexter, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>11-17-60</u>	26. REGISTRAR'S SIGNATURE <u>Velma J. Perkins</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 7 1964

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 Willie Rainey

Licensed Embalmer No. 4982

P. O. Address Neytes, Va

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.