

DATE AMENDED

INSTEAD OF THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED SEP 18 1961

1. PLACE OF DEATH
 a. COUNTY _____
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **915 N. Grand, St. Louis, Mo.** Length of stay in 1b **88 days**
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **VET. ADM. HOSPITAL** Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE **Illinois** b. COUNTY **Marion**
 c. CITY OR TOWN **Salem** Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) **421 S. Franklin St.** Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First **REUBEN** Middle **C.** Last **GARNER** 4. DATE OF DEATH Month **SEPTEMBER** Day **9** Year **1961**

5. SEX **MALE** **6. COLOR OR RACE** **WHITE** **7. Married** **Never Married**
Widowed **Divorced**

8. DATE OF BIRTH **9/23/88** **9. AGE (last birthday)** **72** **10. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired) **Blacksmith**
10b. KIND OF BUSINESS OR INDUSTRY **11. BIRTHPLACE (City and state or country)** **Marion Col., Ill.** **12. CITIZEN OF WHAT COUNTRY** **USA**

13a. FATHER'S NAME **Wylie Garner** **13b. MOTHER'S MAIDEN NAME** **Cora Miller** **14. NAME OF HUSBAND OR WIFE** **Nellie Garner**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **Yes WW-I** **17. INFORMANT** Address **Nellie Garner (Wife), Same add. as 2.**

18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) **RESPIRATORY FAILURE** INTERVAL BETWEEN ONSET AND DEATH **10 MIN**
 DUE TO (b) **LUNG ABCESS AND PNEUMATOCELE** **2 WEEKS**
 DUE TO (c) _____
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
 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.
 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 **VA** **6/13/61** **VA** **9/9/61** **VA** **9/9/61** **and last saw him alive on** **9/9/61**
Death occurred at **8:10 A.M.** **on the date stated above, and to the best of my knowledge, from the causes stated.**

22a. SIGNATURE (Degree or title) **WALTER A. BURKE M.D.** **22b. ADDRESS** **VAH, ST. LOUIS, MO.** **22c. DATE SIGNED** **9/9/61**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Removal** **23b. DATE** **9-10-61** **23c. NAME OF CEMETERY OR CREMATORY** _____ **23d. LOCATION (City, town, or county)** **Salem, Illinois.** (State) _____

24. FUNERAL DIRECTOR **McMacken** **ADDRESS** **Salem Ill** **25. DATE RECD. BY LOCAL REG.** **SEP 11 1961** **26. REGISTRAR'S SIGNATURE** **Earl Smith, M.D.**

1961 8 100

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Elton H. Remelun

Licensed Embalmer No. 4283

P. O. Address St. Louis

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.