

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-037455

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUD

AMENDED

Registration District No. 372 Primary Registration District No. 444 Registrar's No. 44

FILED SEP 24 1962

VS 300
Rev. 4/59

1 1120
2 1120

3
4 0

5 1

6

7 0

8 2

9332X

10

11

1290-2

13-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY WEBSTER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY WEBSTER			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN NIANGUA MO		Length of stay in 1b 17 YRS		c. CITY OR TOWN NIANGUA Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JOHN Middle B Last GARNER			4. DATE OF DEATH Month AUG Day 31 Year 1962		
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-7-1878	9. AGE (last birthday) 84 IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET FARMER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) MISSOURI	
12. CITIZEN OF WHAT COUNTRY U.S.A		13a. FATHER'S NAME JOHN W. GARNER		13b. MOTHER'S MAIDEN NAME MARY MASON	
14. NAME OF HUSBAND OR WIFE ATA		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT ATA GARNER		Address NIANGUA MO		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MEDULLARY PARALYSIS DUE TO (b) CEREBRAL THROMBOSIS DUE TO (c) ARTERIO SCLEROSIS 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.)	
20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> 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>1/18/58</u> to <u>8/31/62</u> and last saw him alive on <u>8/29/62</u> Death occurred at <u>12:15 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <i>[Signature]</i> (Degree or title)		22b. ADDRESS Marshallfield, Mo.	
22c. DATE SIGNED 9/6/62		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 9-2-1962	
23c. NAME OF CEMETERY OR CREMATORY NIANGUA		23d. LOCATION (City, town, or county) NIANGUA MO		(State)	
24. FUNERAL DIRECTOR BARBER-EDWARDS MARSHFIELD		ADDRESS		25. DATE RECD. BY LOCAL REG. 9-17-62	
26. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

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 George Staff

Licensed Embalmer No. 3161

P. O. Address Mr. James M. D.

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.