

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

29612

1. PLACE OF DEATH  
 County Buchanan Registration District No. 85  
 Township St. Joseph Primary Registration District No. 1001  
 City St. Joseph State Hospital #2. Registered No. 1069  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Warren S. Garlock Warren S. Garlock  
 (a) Residence No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M  
 4. COLOR OR RACE W  
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 3, 1876

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
51 6 15

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work Pool hall work  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Kas

10. NAME OF FATHER Geord Garlock

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) N.Y.

12. MAIDEN NAME OF MOTHER Ida Garlock

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Mo

14. INFORMANT State Hosp #2 Recd  
 (Address) St Joseph

15. FILED 18 1927  
John G. Up  
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10/18/27 19  
 17. I HEREBY CERTIFY, That I attended deceased from 7/29/27 19  
 \_\_\_\_\_, 19 10/18/27, 19 \_\_\_\_\_, and that  
 that I last saw h. \_\_\_\_\_ alive on 10/7/27 19 \_\_\_\_\_, and that  
 death occurred, on the date stated above, at 2:30 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

General Paralysis

83 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.  
 CONTRIBUTORY 76 (SECONDARY) (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_  
 IF NOT AT PLACE OF DEATH? \_\_\_\_\_

0 DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? no  
 WHAT TEST CONFIRMED DIAGNOSIS? clinical  
 (Signed) J.H. Romiser, M.D.  
State Hosp #2

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL White Cloud, Kansas DATE OF BURIAL Oct. 20, 1927

20. UNDERTAKER T. Mischoffen ADDRESS 1502 Faraon St

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

