WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—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, and statement of OCCUPATION is very important.

MAY 23 1930

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

11948

1. PLACE OF DEATH
County Cape Girardeau — Registration District No. 130 — File No.
Township Welch — Primary Registration District No. 5282 — Registered No.
City (No. St. Ward)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Child
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Child
6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 4, 1924
7. AGE Years 5 Months 9 Days 5 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(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) Randles Mo
PARENTS
10. NAME OF FATHER Tom Garner
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Mo.
12. MAIDEN NAME OF MOTHER Stella Woodridge
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Mo
14. INFORMANT Jacob Shuls (Address) Delta, Mo
15. FILED 4/13 1930 J. M. Slagle REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 12 1930
17. I HEREBY CERTIFY, That I attended deceased from 3-15, 1930, to 4-12, 1930 that I last saw him alive on 4-12, 1930, and that death occurred, on the date stated above, at 6 P m.
THE CAUSE OF DEATH* WAS AS FOLLOWS: Typho-Malaria
1
26 (duration) 0 yrs. 1 mos. 0 ds.
CONTRIBUTORY (SECONDARY) Tuberculosis of Spine
(duration) 4 yrs. 0 mos. 0 ds.
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) Wm H. Burton, M. D
4-13, 1930 (Address) Delta, Mo

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Kenyon Cemetery — DATE OF BURIAL 4-13 1930
20. UNDERTAKER John Shuls — ADDRESS Delta Mo.

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....

2. FULL NAME .....

(a) Residence. No..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and Sta

Length of residence in city or town where death occurred ..... yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of 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)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

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

14.
INFORMANT ....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

17.
I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to .....
that I last saw h..... alive on....., 19.....,
death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
.....(duration).....yrs. .....mos.

CONTRIBUTORY.....
(SECONDARY)
.....(duration).....yrs. .....mos.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?.....,
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....,
WAS THERE AN AUTOPSY.....
WHAT TEST CONFIRMED DIAGNOSIS?.....
(Signed).....
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CA
(1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SU
HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF B
20. UNDERTAKER	ADDRESS