

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

Do not use this space.

1884

1. PLACE OF DEATH

County Mississippi
Township Lawrence
City Charleston (No. _____)

Registration District No. 566
Primary Registration District No. 3030

File No. _____
Registered No. 1 St. _____ Ward _____

2. FULL NAME

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 4 1/2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH 11 A.M.

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 5, 1849

7. AGE YEARS 84 MONTHS 11 DAYS 0 If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. At home

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Paris, Tennessee

13. NAME James Lewellen

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown, Tennessee

15. MAIDEN NAME Sarah Howle

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown, Tennessee

17. INFORMANT Mrs. Eric Lomberg (ADDRESS) Charleston, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Oak Grove DATE 4/9 34

19. UNDERTAKER (ADDRESS) Lainugh Co. W. Gay Charleston, Mo.

20. FILED Jun 6 1934 J. J. Vernon Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1/5 A. 1934

22. I HEREBY CERTIFY. That I attended deceased from Dec. 26 1933, to Jan. 5 1934

I last saw h. or. alive on Jan 31 1934. Death is said to have occurred on the date stated above, at 11.9.1. m.

The principal cause of death and related causes of importance were as follows:

Hypertensive (traumatic) Pneumonia 1/1/34 following fractured Hip 12/26 1868

Other contributory causes of importance: Infirmitie of old age 10/11

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____ 19 _____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. _____

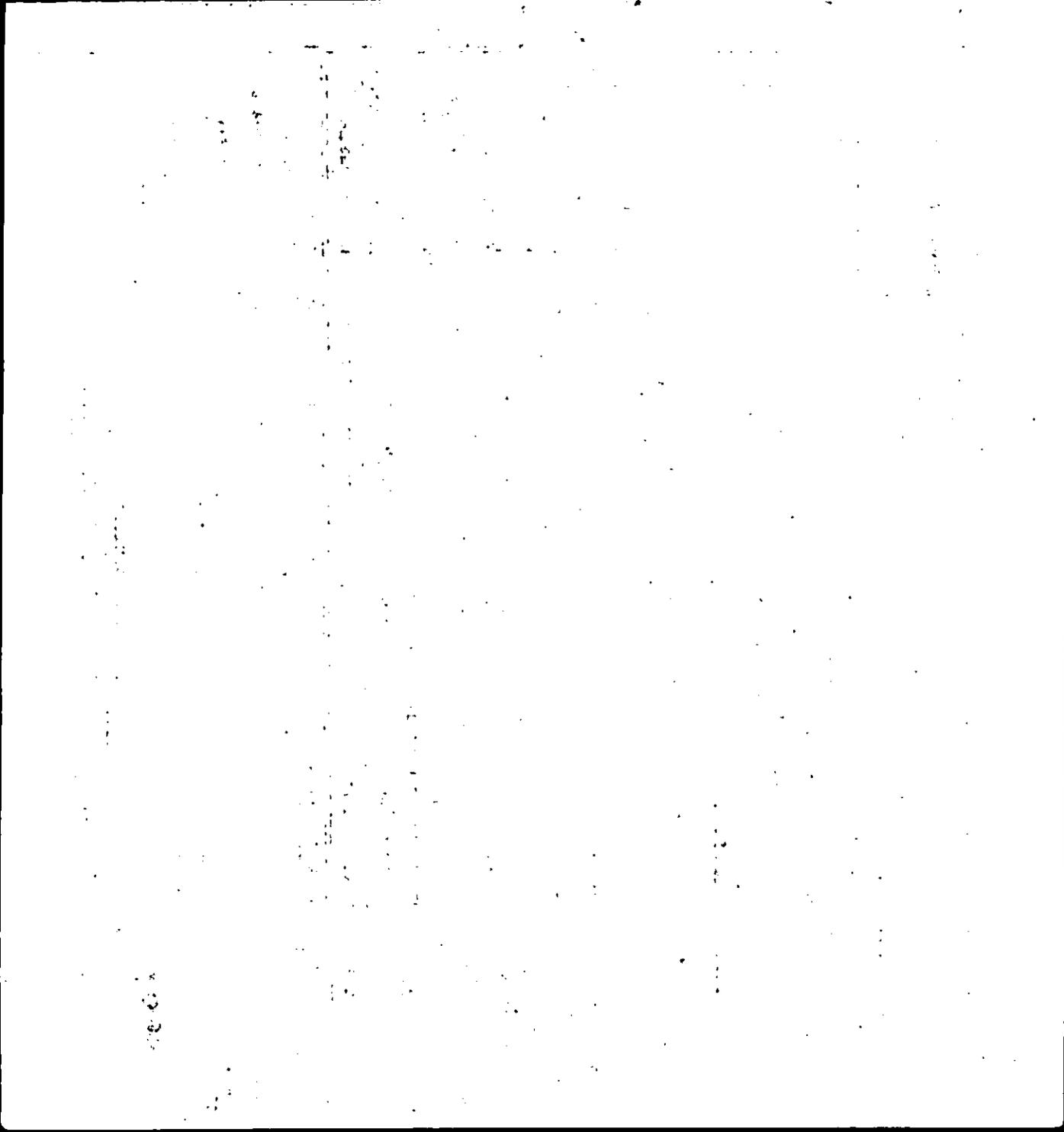
Manner of injury _____ Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____

(Signed) W. S. Howe M. D.
(Address) Charleston, Mo.

Dr. Love
FEB 27 1934

CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. Exact statement of occupation is very important.



DEPARTMENT OF COMMERCE

E. T. McGaugh, M. D.,
Special Agent,
Jefferson City, Mo.

BUREAU OF THE CENSUS

Mississippi

WASHINGTON 1884

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Mrs. Julia Garner
Who died at _____ on Jan. 5 - 1934
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex _____ Color or race _____ Single, married, widowed or divorced: _____

Date of birth _____ Age: Years _____ Months _____ Days _____

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, lawyer, bookkeeper, etc.
(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Where deceased last worked at this occupation: Month _____ Year 1934

Place of birth (State or country) _____

Place of father (State or country) _____

Place of mother (State or country) _____

Principal cause of death: Hypostatic (traumatic) pneumonia following fractured hip - fracture of leg fractured hip. She had Bacterio pneumonia

Other contributory causes of importance _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

If death was due to external causes (violence) fill in also the following: _____

Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____
(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

Name of physician _____

Address of physician _____

Signature of Registrar Frank D. Brown Date filed Jan 7 1934

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. 566

Very truly yours,

Primary Reg. Dist. No. 3030

E. T. McGaugh
Special Agent, M. D.

REPUBLICAN PARTY

MEMBER OF THE BOARD

MEMBERSHIP

MEMBER OF THE BOARD
MEMBERSHIP

MEMBERSHIP

MEMBERSHIP

MEMBERSHIP

MEMBERSHIP

MEMBERSHIP

MEMBERSHIP

MEMBERSHIP