

SEP 27 1937

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

Do not use this space.

32010

1. PLACE OF DEATH

County Stoddard
Township Liberty
City (No.) (No.) St. (Ward)

Registration District No. 838
Primary Registration District No. 6099B

File No. _____
Registered No. _____

2. FULL NAME Nancy Garner

(a) Residence, No. _____ St. _____ Ward _____
(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

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-2-37, 19__

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

22. I HEREBY CERTIFY, That I attended deceased from _____, 19__, to _____, 19__

I last saw h. _____ alive on _____, 19__. Death is said to have occurred on the date stated above, at 8:00 A. M.

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 18, 1845
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____hrs. or _____min.
91 9 23

Date of onset

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

Cardiac Asthenia

Other contributory causes of importance:

Hypertension

12. BIRTHPLACE (CITY OR TOWN) Stoddard County
(STATE OR COUNTRY) Missouri

Name of operation _____ Date of _____

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

FATHER 13. NAME John Fælds
14. BIRTHPLACE (CITY OR TOWN) South Carolina
(STATE OR COUNTRY)

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.

MOTHER 15. MAIDEN NAME Melinda Riddle
16. BIRTHPLACE (CITY OR TOWN) South Carolina
(STATE OR COUNTRY)

Manner of injury _____
Nature of injury _____

17. INFORMANT John Garner
(ADDRESS) Dexter, Mo.

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____

18. BURIAL, CREMATION, OR REMOVAL PLACE Caroline Dowdy DATE 9-5-37 19__

(Signed) Dr. A. D. Harris, M. D.

19. UNDERTAKER Blankenship-Strickland
(ADDRESS) Dexter, Mo.

20. FILED 9-7 1937 Margaret Boone Deputy Registrar (Address) Dexter Mo

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FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

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Do not use this space.

1. PLACE OF DEATH
- (a) County Stoddard Registration District No. 838
- (b) Township Liberty Primary Registration District No. 6098B
- (c) City (d) Street No. St.
- (If death occurred in Hospital or Institution, write its name instead of street and number)
- (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.
2. PRINT FULL NAME Nancy Garner
- (a) Residence, No. St.
- (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED wid

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.

91 9 23

OCCUPATION

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

9. Industry or business in which work was done, as 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)

FATHER

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-2 1937

22. I HEREBY CERTIFY, That I attended deceased from 19... to 19... Death is said to have occurred on the date stated above, at m.

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

Cardiac asthenia
oedema

Date of onset

Other contributory causes of importance:

hypertension
asthma

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?

If so, specify (Signed) B. R. Davis M. D.
(Address) Center mo

SUPPLEMENTARY

20. FILED 9-9 1937 Margaret Boone Local Registrar

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

S-32010