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. Exact statement of OCCUPATION is very important.

DEC'D SEP 26 1938

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

30137
Do not use this space.

1. PLACE OF DEATH
(a) County Shelby Registration District No. 830
(b) Township Salt River Primary Registration District No. 4503 Registered No. 20
(c) City Shelbina (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 Laura Belle Garrison 625
(a) Residence, No. Shelbina Mo. 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

3. SEX female
4. COLOR OR RACE white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed
5A. ~~IF MARRIED, WIDOWED, OR DIVORCED~~ ~~HUSBAND OF~~ (OR) WIFE OF Clabin Garrison
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 2/5/1859
7. AGE YEARS 79 MONTHS 6 DAYS 16 If LESS than 1 day, ... hrs. or ..... min.

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. housekeeper
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) Shelby Co. Mo.

FATHER
13. NAME Hiram Collins 0
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown 9

MOTHER
15. MAIDEN NAME Mary Gose 9
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

17. INFORMANT (ADDRESS) Ada Garrison Shelbina Mo.
18. BURIAL, ~~CREMATION, OR REMOVAL~~ PLACE Shelbina 2 OPS DATE 8/23/38
19. FUNERAL DIRECTOR (ADDRESS) Mission & Barbeler Shelbina Mo.
20. FILED Aug 22 1938 Ruth Joyner Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) aug. 21 1938
22. I HEREBY CERTIFY, That I attended deceased from aug 18, 1938, to aug 21, 1938
I last saw her alive on aug 21, 1938. Death is said to have occurred on the date stated above, at 2 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Myocarditis	3 or 4 days
Other contributory causes of importance: Paralysis of Bowels	2 days

Name of operation ..... Date of .....
What test confirmed diagnosis? clinical Was there an autopsy? no

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) R. L. Caldwell, M. D.
749 (Address) Shelbina Mo.

(Licensed Embalmer's Statement on Reverse Side)

93 [illegible]

RECEIVED
District Health Officer No. 10
District File Number 1038-157
Date Filed 9-16-38

STATEMENT BY LICENSED EMBALMER

I, Marion E. Nelson, Licensed Embalmer No. 3987

hereby certify that the body recorded on the reverse side of this certificate was embalmed by [illegible]

L. E.

No. or by , Registered Apprentice No.

working under my personal supervision.

Signed Marion E. Nelson

Licensed Embalmer No. 3987

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

30137
Do not use this space.

1. PLACE OF DEATH
(a) County Shelby — Registration District No. 830
(b) Township — Primary Registration District No. 45-03 — Registered No.
(c) City Shelbina — (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 Laura Belle Garrison
(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

3. SEX 7
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) 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.
79	6	6	

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....

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED ....., 19....
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 21 1935

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

Myo Carditis — Date of onset

9381

Other contributory causes of importance:
Paralysis of bowels
Hypertension causing a slight stroke of left side and bowels.

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) R. L. Caldwell, M. D.
(Address) Shelbina Mo

SUPPLEMENTARY

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

S-30137