102

REC'D SEP 20 1939

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

29368
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson
(b) Township Washington
or
(c) City Kansas City Mo.
Registration District No. 404
Primary Registration District No. 5558
Registered No.
(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 Susie G. Kinnard Garmon
(a) Residence, No. 8122 Woodland 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 Fe
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND OF~~ (OR) WIFE OF John T. Garmon
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr 30-1860
7. AGE YEARS 79 MONTHS 4 DAYS 3 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House wife
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) Med Calf Co. Kentucky

FATHER
13. NAME Elizah Kinnard
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

MOTHER
15. MAIDEN NAME Amanda Munday
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

17. INFORMANT (ADDRESS) John T. Garmon 8122 Woodland K.C. Mo.
18. BURIAL, CREMATION, OR REMOVAL
PLACE Pleasant Ridge DATE Sept 5 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. M. Kauffman Garden City, Mo.
20. FILED 9-9- 1939 Mrs. Jos T. Brennan Local Registrar. 366

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 3 1939
22. I HEREBY CERTIFY, That I attended deceased from ....., 19.... to Sept. 3, 1939
I last saw her alive on Sept. 3, 1939. Death is said to have occurred on the date stated above, at 1 P. m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Arterio-Sclerosis	
Chronic Pyelitis & Nephritis	
Diabetes	

Other contributory causes of importance: Fall and shock

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... 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? .....
If so, specify .....
(Signed) Geo. H. Jones, M. D.
(Address) 80th & Paseo

(Licensed Embalmer's Statement on Reverse Side)

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.

18 Dec 99

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No. 1530

P. O. Address Garden City

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

If this body is not embalmed, above space should be left blank.

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.

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

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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CERTIFICATE OF DEATH

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Do not use this space.

1. PLACE OF DEATH
(a) County: Jackson — Registration District No.: 404
(b) Township: Washington — Primary Registration District No.: 5538 — Registered No.:
(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: Susie C Kinnard Gammon
(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: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): M

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

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

7. AGE: Years 79 — Months 4 — Days 3 — 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.
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): Sept 3 1939

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:

Date of onset

Arterio Sclerosis
Chronic Interstitial Nephritis — Diabetis

Other contributory causes of importance:
Fall and Shock

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? acc. Date of injury 8-27, 1939
Where did injury occur? K. C. Mo.
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Home
Manner of injury: Fell out of bed
Nature of injury: Fracture Neck L. Femur

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) Geo H Jones, M. D.
(Address) 8029 Paseo

SUPPLEMENTARY

S-29368