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. Exact statement of OCCUPATION is very important.

DEC 1 DEC 13 1939

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

38855
Do not use this space.

1. PLACE OF DEATH

(a) County Adair — Registration District No. 4

(b) Township Salt River — Primary Registration District No. 5001 — Registered No. 264

(c) or City Brashear — (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 64 Flucian Garloch

(a) Residence, No. Brashear 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	W.	Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 16" 1855

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	84	3	19	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
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) W. Va.

FATHER
13. NAME Henry Garloch
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) W. Va.

MOTHER
15. MAIDEN NAME Esther Cuffett
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) W. Va.

17. INFORMANT (ADDRESS) Miss Hazel Garloch Brashear, Mo.

18. BURIAL, ~~CREMATION, OR REMOVAL~~
PLACE Prairie Bird Cemetery DATE 11/7" 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) F. R. Easley Brashear, Mo.

20. FILED Nov. 11, 1939 X
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov. 5", 1939

22. I HEREBY CERTIFY, That I attended deceased from Oct 15, 1939, to Nov 5, 1939
I last saw him alive on Nov 1, 1939. Death is said to have occurred on the date stated above, at 7 P. m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Valvular heart disease (chronic endocarditis)	
Extreme age	

Other contributory causes of importance: 92 a

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) H M Humphrey, M. D.
(Address) Brashear, Mo.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 12-39-2198
Date Filed DEC 11 1939

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 F. R. Easley.

Licensed Embalmer No. 1146

P. O. Address Bracken, Mo.

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

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

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

38855

Do not use this space.

1. PLACE OF DEATH

(a) County: Adair — Registration District No.: 4

(b) Township: Salt River — Primary Registration District No.: 5201 — Registered No.: 264

(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: Lucian Garlock

(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: M

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 84 — Months 3 — Days 19 — 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 1-10 1940 Spencer Freeman, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 5, 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

Other contributory causes of importance:

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) H. M. Humphrey, M. D.

(Address) Brashear Mo

SUPPLEMENTARY

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in stating 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.