

FILED MAR 8 - 1940

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

6687

Do not use this space.

1. PLACE OF DEATH

(a) County GREENE Registration District No. 3225
(b) Township Franklin Primary Registration District No. 5446 Registered No. 72
(c) City SPRINGFIELD or SPRINGFIELD (d) Street No. Stratford R-2 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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

ERMA RILLIS GARLAND
(a) Residence, No. Stratford R-2 St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 9 - 1865

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
74 10 9

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) Pa!

FATHER 13. NAME Elijah Brown

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

MOTHER 15. MAIDEN NAME Sarah Wright

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

17. INFORMANT (ADDRESS) Joseph C Garland
Stratford R-2

18. BURIAL, CREMATION, OR REMOVAL PLACE New Hope DATE 2-13 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wynn
Springfield Mo

20. FILED Feb-15 1940 Albion Barnes
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 11 1940

22. I HEREBY CERTIFY, That I attended deceased from 2-11- 1940, to 2-11- 1940
I last saw u alive on 2-11- 1940 Death is said to have occurred on the date stated above, at 11:15 a.m.
The principal cause of death and related causes of importance were as follows:

Arterio Sclerosis

Date of onset

Other contributory causes of importance:

Heart Block

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) W. Wynn M.D.

(Address) Springfield Mo

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 *Hayd W. Ford*

Licensed Embalmer No. *2710*

P. O. Address *629 W Walnut*

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

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