

Registration District No. **791** Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County.....
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Christian Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **21 days**
In this community **About 15 years** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **John Garrett** **630**
3. (b) If veteran, name war **no** 3. (c) Social Security No. **494-10-5603**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Daisy Garrett** 6. (c) Age of husband or wife if alive **47** years
7. Birth date of deceased **Sept. 21, 1887**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
52 **6** **19** hr. min.

9. Birthplace **Unknown** **Kentucky**
(City, town, or county) (State or foreign country)

10. Usual occupation **Sheet Metal Worker**

11. Industry or business
MOTHER FATHER { 12. Name **James Garrett**
13. Birthplace **Unknown** **Unknown**
(City, town, or county) (State or foreign country)
14. Maiden name **Katherine Beckwith**
15. Birthplace **Unknown** **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Daisy Garrett**
(b) Address **2806 St. Louis Ave**

17. (a) **Burial** (b) Date thereof **Apr. 22, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Lake Charles**

18. (a) Signature of funeral director **Thomas H. Cochran**
(b) Address **2228 St. Louis Ave**

19. (a) **APR 11 1940** (b) **J. D. Beckwith**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County.....
(c) City or town **St. Louis** **20**
(If outside city or town limits, write "RURAL")
(d) Street No. **2806 St. Louis Ave**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **April** day **10**
year **1940** hour **6** minute **55 A. M.**
21. I hereby certify that I attended the deceased from **4/6/40**
_____, 19____, to **4/10**, 19____
that I last saw her alive on **4/9**, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death **Myocarditis**
Chronic
Due to **Lobar Pneumonia** **36 hrs**
Residual
Due to **Pneumia with effusion** **4 days**
Nephritis **?**
Other conditions (Include pregnancy within 3 months of death)
Major findings: **108**
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place)
While at work _____ (a) Means of injury _____
28. Signature **V. J. Menckhoff** (M. D. or other)
Address **Wright's Drug Store** Date signed **4/11/40**

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.

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 *Charles J. Goodheart*
Licensed Embalmer No. *2773*
P. O. Address *Low Me*

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.