

NOV 20 1940

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

Do not use this space.

Reson

1. PLACE OF DEATH

County *Dunklin*
Township *Independence*
City *Keosauqua* (No.)

Registration District No. *288*
Primary Registration District No. *4172*

File No. *35224*
Registered No. St. Ward)

2. FULL NAME

(a) Residence, No. *John J. Garner*
(Usual place of abode) *Keosauqua Hospital* (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 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 *In love*
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Oct 25-1880*
7. AGE YEARS *60* MONTHS *0* DAYS *11* If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Merchant*
9. Industry or business in which work was done, as silk mill, 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) *Dexter Mo*

FATHER 13. NAME *Lucie Garner*

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

MOTHER 15. MAIDEN NAME *Petty Black*

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

17. INFORMANT (ADDRESS) *Billie J. Garner 715 1st St Keosauqua Mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Keosauqua Mo* DATE *11/7* 1940

19. UNDERTAKER (ADDRESS) *Wm J. Leverage 101 Clay Ave Keosauqua Mo*

20. FILED *11-7* 1940 *Wm J. Leverage* Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Oct 6* 1940
22. I HEREBY CERTIFY, That I attended deceased from *Oct 6* 1940 to *Oct 6* 1940
I last saw him alive on *11 Oct 6* 1940 death is said to have occurred on the date stated above, at *3:00 A.M.*
The principal cause of death and related causes of importance were as follows:

Fracture of Skull Base 11/5740
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? *Accident* Date of injury *11/5740* 1940
Where did injury occur *Keosauqua Mo Keosauqua Mo* (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. *Public Highway*
Manner of injury *Auto Accident*
Nature of injury *Fracture of Skull Base*

24. Was disease or injury in any way related to occupation of deceased? *no*
If so, specify
(Signed) *S. P. Kennett* M. D.
(Address) *Keosauqua Mo*

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.

210m
98

RECEIVED

District Health Officer No.

District File Number 140-171

Date Filed 11/14/40

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 35-224

Registration District No. 288

Primary Registration District No. 4172

Registrar's No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Dunklin
(b) City or town Kennett
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME John J. Garner

3. (b) If veteran name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
60 0 11 _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Nov day 6
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

fracture of skull (base)
Due to auto accident
collision with another
Due to auto on state
Highway # 84.

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) acc

(b) Date of occurrence 11-5-40

(c) Where did injury occur? public Hwy (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
public Hwy (Specify type of place) (e) Means of injury _____

23. Signature J. P. Keane (M. D. or other) M.D.

Address 204 S. Main, Kennett Date signed 12-1-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

