

DEPT. OF COMMERCE
BUREAU OF THE CENSUS
APR 25 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

11024

State File No. _____

Registration District No. 411

Primary Registration District No. 2002

Registrar's No. _____

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

1. PLACE OF DEATH: JASPER
(a) County JASPER
(b) City or town JOPLIN
(c) Name of hospital or institution: 217 Michigan
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 DAYS
In this community 10 DAYS
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County JASPER
(c) City or town JOPLIN
(If outside city or town limits, write "RURAL")
(d) Street No. 217 MICHIGAN
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME Karen Sue Garrison
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Mch. day 17
year 41 hour 7 minute 45 A M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

4. Sex FEMALE Color or race W
6. (a) Single, widowed, married, divorced — D
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years

that I last saw h _____ alive on _____, 19____, and that death occurred on the date and hour stated above.
Immediate cause of death _____

7. Birth date of deceased Mch 7 - 1941
(Month) (Day) (Year)
8. AGE: Years Months Days If less than one day
0 0 10 hr. _____ min.

Duration _____
Due to Died suddenly
cause unknown
No violence
Due to _____

9. Birthplace JOPLIN MO
(City, town, or county) (State or foreign country)
10. Usual occupation _____

Other conditions (include pregnancy within 3 months of death) 200
Major findings: Of operations _____
Of autopsy _____

MOTHER FATHER
11. Industry or business _____
12. Name JAMES GARRISON
13. Birthplace JOPLIN MO
(City, town, or county) (State or foreign country)
14. Maiden name HAZEL WOMACK
15. Birthplace WEBB CITY MO
(City, town, or county) (State or foreign country)

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant James E Garrison
(b) Address 217 Michigan
17. (a) BURIAL (b) Date thereof 3/18/41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation CARTHAGE

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? _____

18. (a) Signature of funeral director [Signature]
(b) Address [Address]
19. (a) 3-18-41 (b) [Signature]
(Date received local registrar) (Registrar's signature)

23. Signature [Signature] (M. D. or other) [Signature]
Address Carthage Mo Date signed 41

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

Steve D Parker

Licensed Embalmer No.

2548

P. O. Address

Yofler - Ind

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, fact should be so stated above.