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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **29468**

**FILED AUG 29 1941**

Registration District No. **174**

Primary Registration District No. **4475**

Registrar's No. **18**

**1. PLACE OF DEATH:**

(a) County **Saline**

(b) City or town **Gilliam**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
**Home of Sue Jeter**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **No**  
(Specify whether)

In this community **one day**  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Mo** (b) County **Saline**

(c) City or town **Marshall**  
(If outside city or town limits, write "RURAL")

(d) Street No. **437 No. Odell**  
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)

If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** **Rebecca Mitchel Garrett**

3. (b) If veteran, **X** name war \_\_\_\_\_

3. (c) Social Security **X** No. \_\_\_\_\_

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month **July** day **10**  
year **1941** hour **8** minute **15 P** M.

4. Sex **Female** 5. Color of race **white**

6. (a) Single, widowed, married, divorced **widowed**

6. (b) Name of husband or wife **X**

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

**21. I hereby certify that I attended the deceased from** \_\_\_\_\_ 19\_\_\_\_

that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_

and that death occurred on the date and hour stated above.

7. Birth date of deceased. **December 7 1847**  
(Month) (Day) (Year)

Immediate cause of death. \_\_\_\_\_

*Was seen on \_\_\_\_\_ when I saw her.*

8. AGE:	Years	Months	Days	If less than one day
<b>93</b>	<b>7</b>	<b>3</b>		hr. _____ min.

Due to *Had not been hospitalized by M.D.*

9. Birthplace **Chariton CO, Va**  
(City, town, or county) (State or foreign country)

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

10. Usual occupation **Home**

11. Industry or business \_\_\_\_\_

**PHYSICIAN**

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy **None**

Underline the cause to which death should be charged statistically.

12. Name **Jabez Mitchel**

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

14. Maiden name **Don't know**

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

**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? \_\_\_\_\_

16. (a) Informant **Mrs. Hestir Buis**

(b) Address **Marshall Mo.**

17. (a) **Burial** (b) Date thereof **7 12 41**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Slater Mo.**

18. (a) Signature of funeral director **Hill Brothers**

(b) Address **Slater Mo.**

While at work? \_\_\_\_\_ (Specify type of place)

(a) Means of injury \_\_\_\_\_

23. Signature **M. P. Higgins** (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed **7-12-41**

19. (a) **7-12-41** (b) **Ella Alexander**  
(Date received local registrar) (Registrar's signature)

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

37  
00

RECEIVED  
District Health Officer No. 8,  
District File Number 8-24-41  
Date Filed

**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 *Edgar Moore*

Licensed Embalmer No. *4187*

P. O. Address *State Mo.*

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 29468

Registration District No. 794

Primary Registration District No. 4475

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Saline

(b) City or town Williams  
(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 years, months or days) 1 day

In this community \_\_\_\_\_

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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Rebecca M. Garrett

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day \_\_\_\_\_ year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ days on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

4. Sex H 5. Color or race W 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if \_\_\_\_\_ years

Due to was unconscious when I saw her

Due to had not been treated by m. h.

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

7. Birth date of deceased Dec 7, 1874  
(Month) (Day) (Year)

8. AGE: Years 93 Months 7 Days \_\_\_\_\_  
(If less than one day min)

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

10. Usual occupation \_\_\_\_\_

11. Industry of business \_\_\_\_\_

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 \_\_\_\_\_  
(Burial, cremation, or removal) (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)

PHYSICIAN

Underline the cause to which death should be charged statistically.

2000

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? \_\_\_\_\_

While at work? \_\_\_\_\_  
(Specify type of place) (e) Means of injury

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

State No

SUPPLEMENTARY

SLATER