S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED MAR 14 1945

Registration District No. 818 Primary Registration District No. 1003

State File No. 4256

Registrar's No. 1911

1. PLACE OF DEATH:

(a) County ST. LOUIS

(b) City or town ST. LOUIS (If outside city or town limits, write "RURAL", and name of township)

(c) Name of hospital or institution Missouri Pacific Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 WKS. (Specify whether

In this community 3 WKS. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kans. (b) County

(c) City or town Herrington Kans. (If outside city or town limits, write "RURAL")

(d) Street No. Extra Gang No. 3 (If rural, give location)

(e) Citizen of foreign country? N.R. (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Lee Garrett

3. (b) If veteran, name war No

3. (c) Social Security No.

4. Sex Male

5. Color or race Col

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

6. (b) Name of husband or wife UNKNOWN

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

7. Birth date of deceased 8 (Month) 11 (Day) 1904 (Year)

8. AGE: Years 40 Months 6 Days 13 If less than one day hr. min.

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

10. Usual occupation Labor

11. Industry or business

FATHER
12. Name Saul Garrett
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Annie Mitchell
15. Birthplace (City, town, or county) ARK. (State or foreign country)

16. (a) Informant Louise Poole

(b) Address 2135 Eugenia

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 2-27-45 (Month) (Day) (Year)

(c) Place: burial or cremation Conway Arkansas

18. (a) Signature of funeral director Bennie Love

(b) Address 3103 Washington Ave

19. (a) FEB 27 1945 (Date received local registrar) (b) J. F. Branch (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month February day 24th year 1945 hour 11:30 minute A. M.

21. I hereby certify that I attended the deceased from February 2, 1945 to February 24, 1945 that I last saw him alive on February 24, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Miliary Tuberculosis Lungs involved	1 mo?
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
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? (e) Means of injury

23. Signature J. Schlenker (M. D. or other)

Address 1100 Pac. Hosp. Date signed 2/24/45

(Licensed Embalmer's Statement on Reverse Side)

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 W. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 4575 Aldine

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.