

FILED JAN 21 1946

5381

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: General Hospital No. 20
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 2 Days
(Specify whether years, months or days)

In this community 35 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 1639 Summitt
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME EDWARD GARRISON

3. (b) If veteran, name war None

3. (c) Social Security No. 495-248910

4. Sex Male 5. Color or race Negro

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

6. (b) Name of husband or wife Lillian Garrison

6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased Oct. 14, 1889
(Month) (Day) (Year)

8. AGE: Years 56 Months 2 Days 11
If less than one day hr. _____ min. _____

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

10. Usual occupation Janitor

11. Industry or business _____

12. Name Elyah Garrison

13. Birthplace Ky. 1
(City, town, or county) (State or foreign country)

14. Maiden name Martha

15. Birthplace Ky. 1
(City, town, or county) (State or foreign country)

16. (a) Informant Medical Records Librarian

(b) Address General Hospital No. 2

17. (a) Rural (b) Date thereof 12/29/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Cem.

18. (a) Signature of funeral director Hagens Bros.

(b) Address 1729 Ly die

19. (a) 12-28-45 (b) M. D. Holme
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 25
year 1945 hour 12: minute 05 p. M.

21. I hereby certify that I attended the deceased from Dec. 23, 1945 to Dec. 25, 1945

that I last saw him alive on Dec. 25, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Uremia

Due to Urinary Retention

Due to Benign Prostatic Hypertrophy

Other conditions 137a
(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) _____

(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 [Signature] (M. D. or other) M. D.
Address 600 East 22nd St. Date signed 12/26/45

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

100283

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.....

Licensed Embalmer No.....

P. O. Address.....

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.