S. No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED SEP 12 1947
Division of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39059

Registration District No. 333 — Primary Registration District No. 3074 — Registrar's No. 80

1. PLACE OF DEATH:

(a) County: Scoot

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

(c) Name of hospital or institution: Sikeston Gen Hospt (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 1 Day (Specify whether years, months or days) In this community: 6 Mo

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Scott 100

(c) City or town: Matthews Mo (If outside city or town limits, write "RURAL") 0

(d) Street No. (If rural, give location) 0

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME: Betty F. Garland

3. (b) If veteran, name war:

3. (c) Social Security No.:

4. Sex: F 1

5. Color or race: W

6. (a) Single, widowed, married, divorced: S 0

6. (b) Name of husband or wife:

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

7. Birth date of deceased: 2 (Month) 24 (Day) 1947 (Year)

8. AGE: Years	Months	Days	If less than one day
0	6	10	hr. min.

9. Birthplace: Siseston Gen Hospt (City, town, or county) (State or foreign country) 0

10. Usual occupation: Infant

11. Industry or business:

MOTHER / FATHER

12. Name: Asberry Garlond

13. Birthplace: Danville Ala (City, town, or county) (State or foreign country) 1

14. Maiden name: Rosie Teelford

15. Birthplace: Danville Ala (City, town, or country) (State or foreign country) 1

16. (a) Informant: Asberry Garlond

(b) Address: Rt#3 Matthews, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9/6/47 (Month) (Day) (Year)

(c) Place: burial or cremation: Cave Spring Ala

18. (a) Signature of funeral director: H. W. Albritton

(b) Address: Sikeston, Mo

19. (a) 9-9-47 (Date received local registrar) (b) Mrs T F Henry (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 4 year 1947 hour 4 minute M.

21. I hereby certify that I attended the deceased from 9-4 1947 to 9-4 1947 that I last saw her alive on 9-4 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Congenital Pneumonia	
Due to: Congenital	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy: 108	

PHYSICIAN

Underline the cause of 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: 0

23. Signature: [illegible] (M. D. or other)

Address: Sikeston Mo Date signed: 9-8-47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 947-1208
Date Filed 9-11-47

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 John Allen

Licensed Embalmer No. 2-941

P. O. Address [illegible]

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.