

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

44007
Do not use this space.

FILED JAN 8 1948

1. PLACE OF DEATH

(a) County Jackson Registration District No. 356
 (b) Township Jackson Primary Registration District No. 1206
 (c) City Jackson (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. 138167

2. PRINT FULL NAME MARtha SUE GARRISON

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 11, 1947

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
5 1

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Raymondville Mo

FATHER 13. NAME _____
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 9

MOTHER 15. MAIDEN NAME Violet Garrison
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cedar Grove Mo

17. INFORMANT (ADDRESS) Violet Garrison Raymondville

18. BURIAL, CREMATION, OR REMOVAL PLACE Boone Creek Cem. DATE Dec 13, 1947

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED Dec 30, 1947 Myrtle Craig Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec. 12, 1947

22. I HEREBY CERTIFY, That I attended deceased from Dec 10, 1947 to Dec 12, 1947
 I last saw her alive on Dec 10, 1947 Death is said to have occurred on the date stated above, at 4:30 p.m.
 The principal cause of death and related causes of importance were as follows:

Embolic
 Date of onset _____

Other contributory causes of importance: 119A

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place: _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____ (Signed) J. H. Reed, M. D.
J. H. Reed (Address) _____

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

50M-7-26-37 I 112004

RECEIVED

District

Health Officer No. 1480

District

1-7-48

Date Filed

STATEMENT BY LICENSED EMBALMER

I, _____, Licensed Embalmer No. _____

hereby certify that the body recorded on the reverse side of this certificate was embalmed by _____

_____ L. E. _____

No. _____ or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

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.)