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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED MAR 16 1948

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 96

Primary Registration District No. 5351

Registrar's No. 14

1. PLACE OF DEATH:

(a) County Dallas  
(b) City or town Lead Mine  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 79 yr 3 mo 27 days years, months or days)

3. (a) PRINT FULL NAME Simon Garrison

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

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced M I  
6. (b) Name of husband or wife Clara Garrison 6. (c) Age of husband or wife if alive 76 years  
7. Birth date of deceased Oct 13 1868  
(Month) (Day) (Year)

8. AGE: Years 79 Months 3 Days 27 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Farmer

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

12. Name Simon Garrison

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

14. Maiden name Sarah

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

16. (a) Informant Clara Garrison

(b) Address Lead Mine Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-11-1948 (Month) (Day) (Year)

(c) Place: burial or cremation: Hope Well

18. (c) Signature of funeral director Montgomery - Vaughan

(b) Address Buffalo Mo

19. (a) 3/13/48 (Date received local registrar) (b) Mr J. B. Jones (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Dallas  
(c) City or town Lead Mine (If outside city or town limits, write "RURAL.")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 9 year 1948 hour 8 minutes 30 P.M.

I hereby certify that I attended the deceased from Jan 1 to Feb 9 1948  
that I last saw him alive on Feb 7 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death: Myocardial infarction

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

Major findings: 46B  
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 La Gloria (M. D. or other) MD

Address Madison Mo Date signed 2/14/48

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 7

District File Number 2-48-25

Date Filed 3-15-48

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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.....

Glen D. Williams....., Registered Apprentice No. 13  
working under my personal supervision.

Signed Gayde Montgomery.....

Licensed Embalmer No. 3592

P. O. Address Buffalo, 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.