S. No. 2
M—5-43
5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 1 1948

Registration District No. 149

# THE STATE BOARD OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 16332

Registrar's No. 2081

**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. 10
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days (Specify whether

In this community 37 years
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 4000 Indiana 8
(If rural, give location)

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

If yes, name country

**3. (a) PRINT FULL NAME** Sarah Garrison

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Fe /

5. Color or race W

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

6. (b) Name of husband or wife John Henry

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

7. Birth date of deceased Jan (Month) 7 (Day) 1863 (Year)

**8. AGE:** Years 85 | Months 4 | Days 7 | If less than one day hr. min.

9. Birthplace Lafayette (City, town, or county) Ind / (State or foreign country)

10. Usual occupation Homemaker

11. Industry or business at home

FATHER
12. Name W. S. Keet
13. Birthplace (City, town, or county) Ind. / (State or foreign country)

MOTHER
14. Maiden name Phoebe Houston
15. Birthplace (City, town, or county) Ind. / (State or foreign country)

16. (a) Informant James L. Garrison
(b) Address Humansville, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 5-17-48 (Month) (Day) (Year)
(c) Place: burial or cremation Humansville, Mo.

18. (a) Signature of funeral director C H Blackman & Son
(b) Address Kansas City, Mo.

19. (a) 5-17-48 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

**MEDICAL CERTIFICATION**

20. **DATE OF DEATH:** Month May day 14
year 1948 hour 7 minute 30 P.M.

21. I hereby certify that I attended the deceased from May 12, 1948 to May 14, 1948
that I last saw her alive on May 14, 1948
and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Bronchopneumonia | |
| Due to | |
| Due to | |
| Other conditions Fracture left hip (Include pregnancy within 3 months of death) | |

Major findings:
Of operations 186a 18
Of autopsy None

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) Accident 123

(b) Date of occurrence 5-11-48

(c) Where did injury occur? K. C. Jackson, Mo. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? At home (Specify type of place)

While at work? No (e) Means of injury Fall

23. Signature Wm W. Hart (M. D. or other) MD

Address Med. Dir. Gen'l Hosp. Date signed 5-15-48

(Licensed Embalmer's Statement on Reverse Side)

Dr. Fowler

## 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 O. K. McFarland

Licensed Embalmer No. 4397

P. O. Address Kansas City 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.**