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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30121

FILED SEP 3 - 1952

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7681

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis /
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 814 Rutger

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Arizona
b. COUNTY 8020
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Phoenix 8
d. STREET ADDRESS (If rural, give location) 7251 North 16th St.

3. NAME OF DECEASED (Type or Print)
a. (First) GARRETT
b. (Middle) C.
c. (Last) TIMMONS

4. DATE OF DEATH (Month) (Day) (Year) Aug. 11 1952

5. SEX M 0
6. COLOR OR RACE W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M /
8. DATE OF BIRTH Oct. 22, 1896
9. AGE (In years last birthday) 55 — If under 1 year: Months, Days — If under 1 day: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (City and State or Foreign Country) Missouri 0
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Mike Timmons
13b. MOTHER'S MAIDEN NAME Chloe McIver
14. NAME OF HUSBAND OR WIFE Pansy Timmons

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 490-14-0805
17. INFORMANT'S SIGNATURE OR NAME Thomas Timmons — **ADDRESS** 911 Lafayette St. Louis

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH 2 years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 002X

22. I hereby certify that I attended the deceased from 11 Aug, 1952, *to* 11 Aug, 1952, *that I last saw the deceased alive on* 11 Aug, 1952 *and that death occurred at* 3 P *m., from the causes and on the date stated above.*

23a. SIGNATURE Frank Nelson
(Degree or title) M D 0
23b. ADDRESS 4209 S Kingshighway
23c. DATE SIGNED 12 Aug 52

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal
24b. DATE Aug. 14, 1952
24c. NAME OF CEMETERY OR CREMATORY Poplar Bluff
24d. LOCATION (City, town, or county) (State) Poplar Bluff Mo.

DATE REC'D BY LOCAL REG. AUG 12 1952
REGISTRAR'S SIGNATURE J. Carl Smith M.D.
25. FUNERAL DIRECTOR'S SIGNATURE — **ADDRESS** McLaughlin F. Home 2301 Lafayette Ave.

(Licensed Embalmer's Statement on Reverse Side)

JAN 27 1969

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.....

..... Student Embalmer No. .....

working under my personal supervision.

Student .....
Student Embalmer

Signed J. G. Farris

Licensed Embalmer No. 3384

P. O. Address 2301 Lafayette

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.