

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

2794

FILED JAN 19 1954

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. .... **28**

<b>1. PLACE OF DEATH</b> a. COUNTY		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>2069</b>		
b. CITY (If outside corporate limits, write RURAL and give town or township) <b>St Louis mo</b> c. LENGTH OF STAY (in this place) <b>47da.</b>		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Barnes Hospital</b>		6. STREET ADDRESS (If rural, give location) <b>3117 Kimberly Avenue</b>		
3. NAME OF DECEASED (Type or Print) a. (First) <b>Jennie</b> b. (Middle) <b>E</b> c. (Last) <b>Garrison</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>1 - 2 - 54: 9:45AM</b>		
5. SEX <b>Fem</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>12 - 4 - 1876</b>	9. AGE (In years last birthday) <b>77</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Wayne Co., Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>0</b>
13a. FATHER'S NAME <b>Eliga Strickland</b>		13b. MOTHER'S MAIDEN NAME <b>Martha E. Wilson</b>		14. NAME OF HUSBAND OR WIFE <b>Obediah Garrison</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS	

<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)	<b>MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>HEPATIC FAILURE</b>		<b>2 MONTHS</b>
	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. <b>PERSISTENT CARCINOMA OF STOMACH</b>		<b>2 YEARS</b>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>151X</b>

22. I hereby certify that I attended the deceased from **11-16**, 1953, to **1-2**, 1954, that I last saw the deceased alive on **1-2**, 1954, and that death occurred at **9:45AM**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>FR Bradley M.D.</b>	23b. ADDRESS <b>BARNES HOSPITAL</b>	23c. DATE SIGNED <b>1-2-54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>1/5/54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill Gardens</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo.</b>
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DATE REC'D BY LOCAL REG. <b>JAN 4 1954</b>	REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Drehmann-Harral 1905 Union Blvd.</b>
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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  
by me, or by ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Harvey A. Carver*.....

Licensed Embalmer No. 3.

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING  
to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.