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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 28242

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7596

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: 915 N.Grand,St.Louis,Mo. — Inside Limits: Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): V.A. Hospital — Length of stay in Ib: 2 Days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: St.Charles
c. CITY OR TOWN: Portage des Sioux 09 — Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Garrett D. Middle: Cotner Last:
4. DATE OF DEATH Month Day Year: 8-15-56

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: 9-23-97
9. AGE (In years last birthday): 58 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant
10b. KIND OF BUSINESS OR INDUSTRY: Grocery
11. BIRTHPLACE (City and state or country): Oak Ridge, Mo.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ealm Cotner
14. MOTHER'S MAIDEN NAME: Mary Shelton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW-1
16. SOCIAL SECURITY NO.: None
17. INFORMANT Address: VA Hosp.Records,915 N.Grand,St.Louis,Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PRIMARY MALIGNANCY OF BRAIN, TYPE UNDETERMINED.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
INTERVAL BETWEEN ONSET AND DEATH: 5 MONTHS?

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 193x
20c. TIME OF INJURY Hour, Month, Day, Year a. m. p. m.
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 8-13-56 to 8-15-56 and last saw her/him alive on 8-15-56
Death occurred at 10:15 P. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Daniel Roth M.D.
22b. ADDRESS: VAH, 915 N.Grand,St.Louis,Mo.
22c. DATE SIGNED: 8-16-56

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 8/16/56
23c. NAME OF CEMETERY OR CREMATORY: Memorial Park Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis Co., Mo.

24. FUNERAL DIRECTOR: E.J.Schnur ADDRESS: 3125 Lafayette Ave.
25. DATE RECD. BY LOCAL REG.: AUG 16 1956
26. REGISTRAR'S SIGNATURE: J. Earl Smith, M.D. S.G.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, Coroner, etc. must use only standard nomenclature in item 18. No symptoms will be accepted. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Thomas R. Ferr

Licensed Embalmer No. 37

P. O. Address 3125 Kag

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.