

FILED OCT 28 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43521
STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1121

S. 300
ev. 1-57

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Joseph Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Hillside Nursing Home 718 N. 7th St.		Length of stay in lb 31 years	d. STREET ADDRESS (If outside, give location) 1523 S. 12th St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Margaret Middle Helen Last Garrison			4. DATE OF DEATH Month October Day 14 Year 1957
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 2, 1908
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) employee		10b. KIND OF BUSINESS OR INDUSTRY Tablet Factory	9. AGE (In years last birthday) 49 IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/>
11. BIRTHPLACE (City and state or country) Union Star, Mo.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Isaac Coy		13b. MOTHER'S MAIDEN NAME Mary Jane Carroll	14. NAME OF HUSBAND OR WIFE James Otto Garrison
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 491-10-0382	17. INFORMANT Mr. Raymond Coy, Stewartsville, Mo. Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mitral Stenosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Multiple Sclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4210			INTERVAL BETWEEN ONSET AND DEATH Unk. Unk.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 4210	
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 9/30/57 to 10/14/57 and last saw her her alive on 10/14/57 Death occurred at 4:50 p. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) S. Melaney M.D.		22b. ADDRESS Social Welfare Board 10th & Olive, Patee Hall St. Joseph, Missouri	22c. DATE SIGNED 10/15/57
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 10/16/1957	23c. NAME OF CEMETERY OR CREMATORY Union Star Cemetery	23d. LOCATION (City, town, or county) (State) Union Star, Missouri
24. FUNERAL DIRECTOR Heaton-Bowman	ADDRESS St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. Oct. 21, 1957	26. REGISTRAR'S SIGNATURE Mrs. Robert Fulton

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

MEDICAL CERTIFICATION
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
S.E. Melaney

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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, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *William Spalding*

Licensed Embalmer No. *4535*

P. O. Address *315 1st Ave*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.