

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-004098

STATE FILE NUMBER

FILED JAN 26 1959

Registration District No. 3251 Primary Registration District No. 4480 Registrar's No. 5

300  
1-57

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|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Schuyler</u>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY <u>Putnam</u> |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Greentop</u>            |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | c. CITY OR TOWN <u>Livonia</u><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>rest home</u> |  | Length of stay in 1b<br><u>1 week</u>  | d. STREET ADDRESS (If outside, give location)<br><u>town</u><br>Reside on Form<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print)<br>First <u>Clovie</u> Middle <u>Ellsworth</u> Last <u>Garr</u> |  |  | 4. DATE OF DEATH<br>Month <u>Jan.</u> Day <u>12,</u> Year <u>1959</u> |  |  |
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|                    |                              |   |   |  |   |  |
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| 5. SEX<br><u>M</u> | 6. COLOR OR RACE<br><u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><u>Sept. 29, 1898</u> | 9. AGE (In years last birthday)<br><u>60</u> | IF UNDER 1 YEAR<br>Months <u>3</u> Days <u>13</u> | IF UNDER 24 HRS.<br>Hours <u></u> Min. <u></u> |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>retired farmer</u> | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>general industry</u> | 11. BIRTHPLACE (City and state or country)<br><u>Appanoose Co. Iowa</u> | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u> |
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| 13a. FATHER'S NAME<br><u>Emery Garr</u> | 13b. MOTHER'S MAIDEN NAME<br><u>Lucenda Fleeth</u> | 14. NAME OF HUSBAND OR WIFE<br><u>none</u> |
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|   |   |                                    |                               |
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| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)<br><u>no</u> | 16. SOCIAL SECURITY NO.<br><u>Unknown</u> | 17. INFORMANT<br><u>Doyle Garr</u> | Address<br><u>Memphis Mo.</u> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Glasso-plumaged paralysis</u> |                                  | INTERVAL BETWEEN ONSET AND DEATH  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  | DUE TO (b) _____                 |   |
|   | DUE TO (c) <u>Neuro-syphilis</u> |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>0.265</u>                 |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

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| 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.) |
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|---|--|--|--|
| 20c. TIME OF INJURY<br>Hour _____ 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<br>COUNTY _____ STATE _____ |
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| 21. I attended the deceased from _____ to _____ and last saw him _____<br>Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated. |
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|  |                                      |                                    |
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| 22a. SIGNATURE<br><u>L.W. McDonald</u> (Degree or title) <u>Dr</u> | 22b. ADDRESS<br><u>Unionville Mo</u> | 22c. DATE SIGNED<br><u>1-13-59</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>B</u> | 23b. DATE<br><u>1,14, 59</u> | 23c. NAME OF CEMETERY OR CREMATORIUM<br><u>St. Johns Cem</u> | 23d. LOCATION (City, town, or county)<br><u>Livonia, Mo.</u> | (State) |
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| 24. FUNERAL DIRECTOR<br><u>F.O. Husted &amp; Son-Unionville, Mo.</u> | ADDRESS | 25. DATE RECD. BY LOCAL REG.<br><u>1-14-59</u> | 26. REGISTRAR'S SIGNATURE<br><u>W.S. B. Drake</u> |
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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 *Murl E. Kuster* .....

Licensed Embalmer No. *3304* .....  
P. O. Address .....

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.