

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-004332

STATE FILE NUMBER

FILED MAR 9 1959 Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 71

300  
-57

1. PLACE OF DEATH a. COUNTY <b>Adair</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Adair</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kirksville</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kirksville</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>K. O. H.</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>1103 N. Main St.,</b>

3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Wilbur</b> Last <b>Garrett</b>			4. DATE OF DEATH Month <b>Mar.</b> Day <b>2,</b> Year <b>1959</b>		
--	--	--	--	--	--

5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 19, 1903</b>	9. AGE (In years last birthday) <b>55</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
--------------------	------------------------------	---	--	--	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hotel Employee</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Hotel</b>	11. BIRTHPLACE (City and state or country) <b>Adair county, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
--	---	--	---

13a. FATHER'S NAME <b>James Garrett Sr.</b>	13b. MOTHER'S MAIDEN NAME <b>Julia Ann Potter</b>	14. NAME OF HUSBAND OR WIFE <b>X</b>
--	--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>307-07-4512</b>	17. INFORMANT <b>Harry Garrett, Kirksville, Mo.</b>
---	---	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Circulatory failure + Cardiac Dilatation</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 minutes</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Mural Thrombus Occlusion of Aortic Bifurcation</b>	<b>30 hours</b>
	DUE TO (c) <b>Cor Pulmonale, Emphysema - Bronchial Asthma</b>	<b>25 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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.)
---	--

20c. TIME OF INJURY Hour <b>11:30</b> Month, Day, Year <b>11/8/57</b> g.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 <b>Kirksville, Mo.</b>	COUNTY <b>Adair</b>	STATE <b>Mo.</b>
---	--	--	--	------------------------	---------------------

21. I attended the deceased from <b>11/8/57</b> to <b>3/2/59</b> and last saw <sup>her</sup> <b>him</b> alive on <b>3/2/59</b> Death occurred at <b>11:30 A.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <b>D. Bestmann, M.D.</b> (Degree or title)	22b. ADDRESS <b>Kirksville, Mo.</b>	22c. DATE SIGNED <b>3/3/59</b>
--	--	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>3/4/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Jewell Cemetery</b>	23d. LOCATION (City, town, or county) <b>Adair county, Mo.</b>
--	----------------------------	--	---

24. FUNERAL DIRECTOR <b>Charles E. [unclear]</b> ADDRESS <b>Kirksville, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>3-3-1959</b>	26. REGISTRAR'S SIGNATURE <b>Doris W. Rathoff</b>
---	---	--

(Licensed Embalmer's Statement on Reverse Side)

ALL diseases in Part I must be causally related.  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.  
MEDICAL CERTIFICATION  
D. BESTMANN, M.D.

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 *Kenneth E. Hayes* .....

Licensed Embalmer No. *4890* .....

P. O. Address *Linkville, Mo* .....

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.