

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008324
STATE FILE NUMBER

FILED APR 3 1959

Registration District No. 13

Primary Registration District No. 3002

Registrar's No. 51

300
-57

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Barry		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Barry	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Monett		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Purdy 0650
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Vincent's Hosp.		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) Route #1
3. NAME OF DECEASED (Type or print) First Nancy Middle Ann Last Garrison			4. DATE OF DEATH Month March Day 29 Year 1959
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 29, 1959
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY Inf	9. AGE (In years last birthday) Months 3 Days 3 Hours Min.
11. BIRTHPLACE (City and state or country) Monett, Mo		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13a. FATHER'S NAME Ralph Garrison		13b. MOTHER'S MAIDEN NAME Velma Shoemaker	14. NAME OF HUSBAND OR WIFE
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.	17. INFORMANT Mrs. Velma Garrison Address Purdy, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial hemorrhage (Probable)			INTERVAL BETWEEN ONSET AND DEATH 3 days
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)			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.) 7600	
20c. TIME OF INJURY 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 COUNTY STATE
21. I attended the deceased from 3-19-59 to 3-21-59 and last saw her alive on 3-21-59 Death occurred at 540 A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Mary Newman M.D.		22b. ADDRESS Cassville, Mo.	22c. DATE SIGNED 3-21-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE March 22-59	23c. NAME OF CEMETERY OR CREMATORY Muncy Chappell	23d. LOCATION (City, town, or county) (State) Barry Co. Missouri
24. FUNERAL DIRECTOR McQueen Funeral Home, Wheaton Mo		25. DATE RECD. BY LOCAL REG. 3-22-59	26. REGISTRAR'S SIGNATURE Mrs P.H. Cook

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 *Paul D. Humbert*

Licensed Embalmer No. *4576*
P. O. Address *Cassville 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.