

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

## 59-028448

FILED VS AUG 26 1959 70

STATE FILE NUMBER

DED

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. 44

1. PLACE OF DEATH a. COUNTY <b>Clark</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Clark</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Alexandria</b>		Length of stay in 1b <b>30 years</b>		c. CITY OR TOWN <b>Alexandria</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Own Home</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Judson</b> Middle <b>J.</b> Last <b>Garrett</b>				4. DATE OF DEATH Month <b>Aug.</b> Day <b>13</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>3/15/1892</b>	9. AGE (last birthday) <b>67</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>	11. BIRTHPLACE (City and state or country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13a. FATHER'S NAME <b>Oliver Garrett</b>			13b. MOTHER'S MAIDEN NAME <b>Sarah Hales</b>		14. NAME OF HUSBAND OR WIFE <b>Lara Garrett</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes 1918</b>			16. SOCIAL SECURITY NO. <b>486-14-5312</b>	17. INFORMANT Address <b>Mrs. Lara Garrett, Alexandria, 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>Cancer head of Pancreas</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4-4-59 to 8-13-59</b>
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)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 _____ a.m. _____ p.m. Month, Day, Year _____							
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 <b>4-4-59</b> to <b>8-13-59</b> and last saw him alive on <b>8-13-59</b> Death occurred at <b>7-45 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>J. R. Manning D.O.</b>				22b. ADDRESS <b>Kahoka Mo</b>		22c. DATE SIGNED <b>8-15-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Aug. 16, 1959</b>	23c. NAME OF CEMETERY OR CREMATOR <b>Kahoka Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Kahoka Missouri</b>			
24. FUNERAL DIRECTOR <b>Otis L. Gutting</b>		ADDRESS <b>Kahoka, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>8/22-59</b>	26. REGISTRAR'S SIGNATURE <b>J. B. Bridger</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1965

SEP 16 1965

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Alb L. Jettison

Licensed Embalmer No. 2965

P. O. Address Surry

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.