

# MICHIGAN DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAY 25 1960

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=60-020946

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **5282** STATE FILE NUMBER

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)				
a. COUNTY				a. STATE <b>Mo</b>		b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS Mo</b>		Length of stay in 1b		c. CITY OR TOWN <b>ST. LOUIS</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>FIRMIN DESLOGE Hosp</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>3913 LAFAYETTE</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH				
First <b>SAM</b>		Middle <b>L</b>		Last <b>GARNER</b>		Month <b>MAY</b> Day <b>18</b> Year <b>1960</b>		
5. SEX <b>M</b>	6. COLOR OF RACE <b>W</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>DEC 13 1913</b>	9. AGE (last birthday) <b>46</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>WAREHOUSEMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOWE. Co.</b>		11. BIRTHPLACE (City and state or country) <b>LITHUM Mo</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>		
13a. FATHER'S NAME <b>SILAS GARNER</b>			13b. MOTHER'S MAIDEN NAME <b>MATILDA STATLER</b>			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) <b>YES WWII</b>			16. SOCIAL SECURITY NO. <b>496-14-3227</b>		17. INFORMANT Address <b>ROBERT ALLARD IMPERIAL Mo</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>ACUTE CEREBRAL ANOXIA</b>								
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								
DUE TO (b) _____								
DUE TO (c) <b>307X</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>IMPENDING DELERIUUM TREMENS</b>					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 checked="" 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. _____		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>May 16</b> to <b>May 18</b> and last saw him alive on <b>May 18, 1960</b> Death occurred at <b>May 18, 1960</b> <b>9:30 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>Raymond B. Slaven M.D.</b>				22b. ADDRESS <b>Firmin Desloge Hospital</b>		22c. DATE SIGNED <b>May 19, 1960</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>MAY 20-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>NATIONAL CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>JEFFERSON BARRACKS Mo</b>			
24. FUNERAL DIRECTOR ADDRESS <b>HEILIGTAG - IMPERIAL Mo</b>			25. DATE RECD. BY LOCAL REG. <b>MAY 19 1960</b>		26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

-m81

**STATEMENT BY LICENSED EMBALMER**

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

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

Signed Arthur W. Heiligt

Licensed Embalmer No. 3878

P. O. Address Imperial

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to 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.