

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-045578

LED VS DEC 21 1960

STATE FILE NUMBER

Registration District No. 99 Primary Registration District No. 4168 Registrar's No. 54

1. PLACE OF DEATH a. COUNTY <u>DeKalb</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Clinton</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Maysville</u>		Length of stay in 1b <u>1yr.</u>	c. CITY OR TOWN <u>Cameron</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Sunset Nursing Home</u>		Inside Limits: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>816 W. Prairie</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <u>MAGGIE IDELLETA GARRISON</u>	First Middle Last	4. DATE OF DEATH <u>Dec. 11, 1960</u>	Month Day Year
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-24-1875</u>	9. AGE (last birthday) <u>85</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Ida, Ill.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Mike Malaney</u>	13b. MOTHER'S MAIDEN NAME <u>Bertha Cross</u>	14. NAME OF HUSBAND OR WIFE <u>Milo Garrison</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>no</u>	17. INFORMANT <u>Muriel Egbert, Long Beach, Calif.</u>	Address
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18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis Heart Disease</u>	DUE TO (b) <u>Congestive heart failure</u>	DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			

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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour <u>1</u> Month, Day, Year	a.m. p.m.
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Osborn, Mo.</u>	COUNTY <u>Osborn, Mo.</u>	STATE
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21. I attended the deceased from <u>July 1959</u> to <u>Dec 1960</u> and last saw her alive on <u>Dec 11, 1960</u> . Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>[Signature]</u> (Degree or title)	22b. ADDRESS <u>Maysville</u>	22c. DATE SIGNED <u>12/15/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Dec. 11, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen</u>	23d. LOCATION (City, town, or county) (State) <u>Osborn, Mo.</u>
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24. FUNERAL DIRECTOR <u>Poland Funeral Home, Cameron, Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>12-14-60</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed Robert F. Palani

Licensed Embalmer No. 477
222 Main
P. O. Address Camden

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.