

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-046707

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 287

STATE FILE NUMBER

FILED DEC 9 1963

1. PLACE OF DEATH a. COUNTY SCOTT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY SCOTT	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SIKESTON		Length of stay in lb 29 hrs.	c. CITY OR TOWN SCOTT CITY Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION MO. DELTA COMMUNITY HOSPITAL		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) INDIA GALE GARNER			4. DATE OF DEATH Month 12 Day 1 Year 63		
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-29-63	9. AGE (last birthday) 2 days	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE	10b. KIND OF BUSINESS OR INDUSTRY INDIAN RESERVE	11. BIRTHPLACE (City and state or country) MISS CO. MISSOURI	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME GLEN GARNER	13b. MOTHER'S MAIDEN NAME INDIANA REEVES	14. NAME OF HUSBAND OR WIFE _____
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates) NO	16. SOCIAL SECURITY NO. _____	17. INFORMANT Address ESTELLE HALEY (AUNT)
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18. CAUSE OF DEATH (Enter only one cause) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ABNORMAL PULMONARY VENTILATION		INTERVAL BETWEEN ONSET AND DEATH 2 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) PREMATURITY - 34 WK. GESTATION		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 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 _____ a.m. _____ p.m.	Month, Day, Year _____
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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 _____
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21. I attended the deceased from **11-29-63** to **12-1-63** and last saw her alive on **12-1-63**
Death occurred at **4:35 A.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Andrew B. Smith MD</i>	(Degree or title)	22b. ADDRESS Sikeston Mo.	22c. DATE SIGNED 12-3-63
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12-1-63	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery	23d. LOCATION (City, town, or county) Charleston, Missouri	(State)
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24. FUNERAL DIRECTOR McMikle, Charleston, Missouri	ADDRESS Charleston, Missouri	25. DATE RECD. BY LOCAL REG. Dec 6, 1963	26. REGISTRAR'S SIGNATURE <i>Janette Walker</i>
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DATE AMENDED

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300 Rev. 4/59
1/009
2/1000
3
4 1
5 0
6
7 0
8 1
9/625
10
11
12 1-0
13 2-0

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 Bruce R. Justice

Licensed Embalmer No. 5749

P. O. Address Chuliston, Md.

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.

Permit renewed Dec 1 - 1963