

FILED MAY 12 1947

Registration District No. ....

Primary Registration District No. 4296

Registrar's No. ....

1. PLACE OF DEATH  
**Sullivan**

(a) County **Browning**

(b) City or town **Browning**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **/**

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **21/ 25 years** (Specify whether years, months or days)

In this community **25 years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Sullivan 105**

(c) City or town **Browning** **0**  
(If outside city or town limits, write "RURAL") **0**

(d) Street No. **0**  
(If rural, give location) **0**

(e) Citizen of foreign country? **0** (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME **Irene Agnes Garrett**

3. (b) If veteran, name war **---**

3. (c) Social Security No. **---**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **4** day **28**  
year **1947** hour **3** minute **05** P. M.

4. Sex **fe** 5. Color or race **w**

6. (a) Single, widowed, divorced, or **married**

6. (b) Name of husband or wife **J. W. Garrett** 6. (c) Age of husband or wife if alive **57** years

7. Birth date of deceased: **April 11 1893**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **26 April 28 1947** to **April 28 1947**, that I last saw her alive on **April 28 1947**, and that death occurred on the date and hour stated above.

8. AGE: Years **54** Months **0** Days **17** If less than one day hr. min.

Immediate cause of death **Cerebral hemorrhage** **10 hrs**

9. Birthplace **Missouri**  
(City, town, or county) (State or foreign country)

Due to

Due to

10. Usual occupation **House wife**

Other conditions **Hypertensive heart disease 3 yrs.**  
(Include pregnancy within 6 months of death)

11. Industry or business

Major findings: Of operations

12. Name **George G. Alexander**

Of autopsy **939**

PHYSICIAN

Underline the cause to which death should be charged statistically.

13. Birthplace **Virginia**  
(City, town, or county) (State or foreign country)

14. Maiden name **Bell Northcott**

15. Birthplace **Ill.**  
(City, town, or county) (State or foreign country)

16. (a) Informant **J. W. Garrett**

(b) Address **Browning**

17. (a) Burial **Jenkins** (b) Date thereof **4-30-47**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Wade Funeral Home**

18. (a) Signature of funeral director **Browning, Mo.**

(b) Address **Browning, Mo.**

19. (a) **May 1, 1947** (b) **Elva Crookshank**  
(Date of local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (c) Means of injury **0**

23. Signature **J.R. Martin** (M. D. or other)

Address **Browning** Date signed

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

**DISTRICT HEALTH OFFICE  
Cameron, Mo.**

**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed Gerald I. Wade

Licensed Embalmer No. 4172

P. O. Address Browning

**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 this body is not embalmed, fact should be so stated above.**